Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 8.55 A M De Eline Day Physician/ stelle Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Good Samaritan Nursing Center 7. Age (In yrs. last birthday) 94 yrs 8. Date of Birth (Month, Day, You Sept. 16, g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Numbe **Funeral** Year) 1916 Hours 1 □ M 2 🖟 Days 215-03-5177 Baltimore, MD **Director** Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County death with the Maryland Director Baltimore Maryland N/A 1 🎇 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 5514 Purdue Avenue 21239 23a United States items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give ō þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 XXNo Specify: Specify: "natural", 3 XWidowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ulth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Hecht Company Security 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Baumarten Mary Hicks permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print)
Frank J. Pondolfina (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4424 Macworth Place, Nottingham, Maryland 21236 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory, or, other place)
Geners of Faith
Canetery ndoer 22 Rosedale, Maryland 4 Donation 5 Other (Specify) Name and Address of Facility
Evans Funeral Chapel & Cremation Services Parkville
8800 Harford Road, Parkville, Maryland 21234
Approximation Approximate Interval Between Onset and Death ar 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Implediate Cause (Final Physician/ No disease or condition Medical sulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 Hunknown Division of Vital Records, 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate Yes 25 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) ours after death.

erai Director: After this certific filled in by the funeral director, Be examiner? Other: 2 **X**No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural
2 Accident 5 Pending work? 2 🗌 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital
within 24 hours a
To the Funeral C
completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mis 32. Registrar's Signature Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 03:30 AM DELEMBER 21 2010 Physician/ Cornelia Jane Pescetto Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) BALTIMORE **Examiner** TOW SON CENTER SAINT JOSEPH MEDICAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Security Number April Por 1920 Mary Yand Days Hours Months **Funeral** 1 □ M 2 🛛 F 90 220-01-4529 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f shov 10a. State 1 Yes 2 XNo Examiner must be notified at Director Parkville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò USA 21234 Funeral 2907 Conroy Court Apt. A 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 11. Marital Status Armed Forces? white 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify: 0 21215-0036 If Yes Give 3 Midowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Medical 15. Decedent's Education (Specify only highest grade completed) & P Telephone Switchboard Operator College (1-4 or 5+) and Mental Hygiene. Elementary/Seconday (0-12) Company the 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland UNKNOWN Cornila permit. Page 1 and 2 should be file Department of Health and Mental Inportant: If item 27 is marked of any injuy or other traumatic evel once. မ Nelson Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2911 Oakcrest Avenue-Parkville, Maryland 21234 Patricia Pescetto-daughter in law 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition Parkwood Cemetery Parkville, Maryland Dec.24,2010 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licensee -ondraé 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ueeo.K Immediate Cause (Final Acute MADOXIC hysician/ disease or condition Due to (or as a consequence of): resulting in death) Medical week Rena Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events. Due to (or as a consequence of): week Examine Faclure Congestine attending physician and I for use as the burial-transit Wick mesentric resulting in death) Last Ischemia Is Ohemic Physician/Medical 0351ble or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy
5 Other (specify) Year 23b. Was decedent pregnant Live Birth 2 Fetal death Month Day in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ≦ 3 Probably 4 Unknown 2 No 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No this certificate has perform 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be (director, 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 🗌 Yes Certificate: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral director. 28d. Describe how injury occurred Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Manner of Death work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 1 Naturai
2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title of certifier

G

Jungeling

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BANGORIA

D65641

OSLER DRIVE TOWSON, MARYLAND

29d. Date signed (Month, Day, Year)

DECEMBER 21, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 26 PM Medical give street and numbe **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 Months Days Hours 08/11/67/11/91/68 Maryland 42 Yrs 212-02-7202 **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 ☐ No Baltimore MD N/A 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 347 Smallwood St. 21223 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Security Guard 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy Lee Brown James Rhue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 178 Glendon Trace Dr., Reisterstown, MD 21136 Aaron Chever(nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. 12/28/10 Baltimore, MD 21. Signature of Funeral Service Licensee PA 21217 そのなっている FBirown Jr. Funeral 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the deat. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. terval Between nset and Death Immediate Cause (Final h sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months
1 Yes 2 100 Pregnant at time of death 5 Other (specify) sate has been signed by the s page 2 should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 100 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical examiner. 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes 2 10 မ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dippatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 335 12/20/2010 066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEINFELD 22 SOUTH CEVIMIEY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 15^{Day} Charles Wilbur Rampmeyer 2010 11:00aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death The Chesapeake House Middleriver Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days (Month, Day, Year) 2/31/1930 1X M 2 □ F Hours Min. Yrs. Director 217-26-4358 79 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Middleriver 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7336 Chesapeake Road 21220 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 9 Completed by 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify: 3 Widowed 4 XDivorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) <u>Engineer</u> Johns Hopkins 8th æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Franklin Charles Rampmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8015 Kimberly Road, Baltimore, MD 21222 Lisa Marie Rampmeyer 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 12/18/10|Orlando, FL 4 X Donation 5 ☐ Other (Specify) MedCure Signature of Funer, Sin ice Licensee 22. Name and Address of Facility 8018 Sunport Drive MedCure Orlando, FL 32809 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 4 YRS Enysician/ disease or condition resulting in death) a. ADVANCED ALZHEIMER'S DEMENTIA Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Due to lor as a considuent Examir cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Month Day Pregnant at time of death Yes 2 No detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ sign. or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed General Debility 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy certificate completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at After 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M.D. D0017728 December 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21236 Baltimore, MD 8022 Belair Rd. Ba Yin Oung, M.D.

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS, G910 12/22/2010 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day Physician/ Rebbert 3:15 P M Michael John December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8233 Cornwall Road Baltimore Co. Dundalk 8. Date of Birth
(Month, Day, Year)
Jan. 5,1948 Social Security Number Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours Country)
Maryland 1**X** M 2 □ F 216-52-4310 Jan. Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director Baltimore City N/A 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5054 Erdman Avenue United States 21205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes þ within 72 hours after Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. Vietnam 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Schools n and Mental Hygier r is marked other t 12 Years Maintenance other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marliee L. Law George F. Rebbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau. 21222 8233 Cornwall Road Dundalk, Maryland Michele Crislip (Daughter) Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 【★ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Hilltop Service Corp. 12/21/2010 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature di Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 0 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical Cancel Lung disease or condition resulting in death) Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Que to for as a nonsequence off Examin Cause (Disease or iinjury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown detached the been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autonsy perform certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Daughter's examiner? Other: 2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Yes 2 No 5 Pending 1 🖊 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified DOUS7465 12/20/10 TISKAJ APAMINID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. S. Rajapakh, M.D. 2835 Smith Av. 5-703, Baltimore, MD. 21209

State Registrar DEC 2 2 2010

32. Registrar's Shinatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER. 2010 2:20 PM BETTY LOU RASKIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW CARE CENTER BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Min 1 M 2 XF 0470971924 MD Director 218-32-8981 Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 RIVER OAKS CIRCLE 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 X Never Married 2 Married ☐ Yes 2 X No 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify: 3 Divorced WHITE Completed Year or Dates the Medica 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **PROFESSOR EDUCATION** Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ ROSE FRANK MOSES RASKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN RASKIN/SISTER RIVER OAKS CIRCLE, BALTIMORE, MD other Baltimore. tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Nourial 2 Cremation 3 Removal from State BONAVENTURE CEMETERY 12/21/2010 4 ☐ Donation 5 ☐ Other (Specify) SAVANNAH, GA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final Physician/ RENAL FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) xaminer YEARS CROHNS DISEASE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) PYODERMA GANGRENOSUM MONTHS that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death Yes 2 XNo 4 ☐ Pregnam: 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PULMONARY EMBOLISM Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? STEROID INDUCED DIABETES MELLITUS 24a. Was an autopsy performed? Yes 2 XNo 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2**X** No ျှ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After (Month, Day, Year) 1 XNatural 5 Pending injury 1 Ves 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only one) 29b. Signature and title of certific

13 31. Date filed (Month, Day, Year)

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grea

nought

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

800

D043 83

29d. Date signed (Month, Day, Year) December 22, 2010

1505 Horman Bay View circle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 14^{Pay} 2010^{ear} 5:47 P M Andrew Reiter, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours Min 12 onth, 707 (Par) 1933 Mary land 1**√**2 M 2 □ F 213 32 4232 77 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2 🛣 No Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Seminary Drive. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify. White Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Commercial Real Estate Appraiser Real Estate Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Walter A. Reiter, Sr. Mary C. Cahill 19a. Informant's Name/Relationship (Type, Print)

June Reiter - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20 Seminary Drive. Lutherville, MD 21093 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State New Cathedral Cem. 12/18/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Home of Catonsville Inc. 21. Signature of Funeral Service Lice M0105D 630 Edmondson Ave. Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physiciani Hepatocellular ucs disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Cinhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events alcohol attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year n signed by the a ld be detached f Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No ☐ Yes 2 N 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) s after death.

al Director: After this of Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) 1 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check diet the three, date and blane, and dies to the cause(s) and me Certifying Nursa Practioner: To the best of my knowledge, death . Signature and title of certifier 00070635 12/15/10 Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105 Baltimore MID 21204 Patel 6701 N chames St 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

		1- For State Registrar	te of Maryla			nt of He e of De		d Men		F	Reg. No	20	10	050
Physici ledical Exami		Decedent's Name (First, Middle, RAYMOND		SENBER	C					2. Date of De: Month December	Dav	Year		3. Time of Death 0820 hrs
		4a. Facility Name (if not institution,					ty, Town, or	Location o	of Death	Decembe	4	c. County of Out-Of-St		
Funeral		In Port of Coco Cay 5. Social Security Number 6	Sex	7. Age (In yrs.	last birthda		hamas Inder 1 Yea	r I If Unde	er 24Hrs.	B. Date of B				place (State or
Director			1 X M 2 F	88			onths Day	_		10/05	•	1	Foreign	
any		Usual Residence of Decedent 10a. State 10b. County		110c Cit	y, Town or	Location								10d. Inside City Limits
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Maryland 28a-f show <u>1 at once.</u>	Director	10e. Street and Number	GOTIEKI		AVEKI		Zip Code		_		10g. Ci	tizen of Wha	t Count	ry?
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ath wit frems 2 st be n	Funeral	11. Marital Status 1 Never Married 2 X Mari	ried Armed Fo		U.S. 1		edent of His ecify Cubar			ecify Yes or N Rican, etc.)	0-	14. Race - White,		an Indian, Black,
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-	-4 or 5+)		OWNER						ADVER'	гтст	NC.
5-0036 iled within 7 Hygiene. I other than		17. Father's Name (First, Middle, L	ast)			OWNER		18,Mother	's Name	(First, Middle,			1.131	.NG
2121 2121 3uld be fill 1 Mental I 1 marked ic event,	Be	MAURICE 19a. Informant's Name/Relationship	n /Time Drint)	ROSE	NBERG		1000 (Start		ETTI	tural Route Nu	mala a d			DOFF
MD 21 12 should 12 should 127 is man	우	REBECCA SOFFEI		:R			•							Y 10069
Te, No. 1 and 1 Health		20a. Method of Disposition 1 XBurial 2 Cremation		20b	. Place of D	Disposition (Name of ce		, v D	Date	20c.	Location - 0	City or T	own, State
Pages nent of ant: Ib		4 Donation 5 Other Spec				EHUDA		ERY	12/2	21/2010		UPPER	DAR	RBY, PA
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Oeparment of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me		21. Signature of Funeral Service Li					and Address	s of Facility	so	OL LEVI	NSO			
Physician	-	3a. Part I. Enter the disease, or co		used the deat	h. Do not e					ROAD,				MD 21208 Approximate Interval
edical		failure. List only one cause or Immediate Cause (Final disease	n each lind a. Atheroscler	otic Cardio	vascula	r Dis ea se)							Between Onset and Death
		or condition resulting in death)	Due to (or as a	consequence	of):									
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Box 68760, death certificate be execut he attending physician and of for use as the burial - tran		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		outcome of pre orth	egnancy 2	Fetal de	ath 3	Ectopic	c pregna	ncy	23	3d. Date of o Month	lelivery Da	ay Year
lox 6 leath cer e attendi for use	sicia	1 Yes 2 No 9 Unkno		ant at time of o	death 5	Other (Specify)							
that the dened by the detached i		Part II. Other significant conditio			resulting in	n the underl	ying cause (given in Pa	art I.	23e. Did	tobacco	use contrib	ute to ti	ne cause of death?
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be writin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	3 Suicide 6 Could	not be 28e. Place	e of Injury - At	home, farm	n, street, fac	tory, office t	ouilding, et	c.	28f. Location or Town,		and Number	or Rur	al Route Number, City
Hospit. 74 hour. Funers	I	4 Homicide	sician: To the best	t of my knowle	edge, death	occurred a	t the time, d	ate and pla	ace, and	due to the car	use(s) a	ind manner a	as state	d.
the the	Medical	one) 2 Medical Exam	iner:On the basis of and manner st	of examination	-		n my opinior	n, death oc			e and p	lace, and du	e to the	cause(s)
₽ ₹ ₽ ⊼ I		29b. Signature and title of certifier					29c. Licens					. Date signe		

Registrar

State 31. Date filed (Month, Day, Year) istrar IFC 2 2 2010 32. Registrar's Signatur

Theodore M. King, Jr., MD. Assistant Medical Examiner

O.C.M.E.

OCME

111 Penn Street, Baltimore, MD 21201

December 17, 2010

10-09755

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Clifford Reed 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 18, 2010 0258 hrs Medical Examiner Clifford Lebine 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Bon Secours Hospital If Under 1 Year I If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Director 51 215-84-3631 09 14 59 Country) MD 1 M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 Yes 2 No Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21223 2561 West Fairmount Ave Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1 X Yes Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 Yes 2 X No specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12th grade Dish Washer Hyatt Regency 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be \$arah Maniault Charles William Reed and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 ည 19a. Informant's Name/Relationship (Type, Print) nt of Health and Mit. If item 27 is m Mona Reed-Wife Baltimore, 2561 West Fairmount Ave, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/22/2010 Woodlawn, Md Woodlawn Donation 5 Other Specify: permit. 2 Si ature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave. Baltimore. Md Approximate Interval Part I. Enter the disease, or complications it at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Methadone Intoxication Immediate Cause (Final disease *_*xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and trans Physician/Medical 23a,pt.II,27,28a-f per me g911 1-28-11 vt X UNPENDED **AMENDED** attending physician or use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year 1 Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Š 1 Yes 2 ✓ No 3 Probably 4 Unknown Cirrhosis of Liver Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? ✓ Yes 2 No this certificate 1 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 PER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes ဥ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 Yes 2 No 5 Pending unknown fd 12-18-10 death. 1 Director: ed in by the f unknown 2 Accident Investigation 28f Location (Street and Number or Rural Route Number, City or Town, State) 2561 W. Fairmount Ave. Baltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide thin 24 hours a determined (Specify) house 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E December 18, 2010 The Whell Olyone 30. Name and address of person who completed cause of death (Item 23a)

State Registrar Margarita Korell MD.

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEC. 16ª 20 TO 7:20 A M JEAN VIRGINIA RUOTOLO JEAN DELORES RUOTOLO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMONIUM BALTIMORE STELLA MARIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7, Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days (Month, Day, OCT. 31 Hours 1 □ M 2 😾 F Director 220-14-5040 89 1921 MD Usual Residence of Decedent 28a-f show 10b, County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No MD BALTIMORE OVERLEA 10g. Citizen of What Country? 5 10e. Street and Number 10f. Zip Code items 23a Funeral 21236 5125 TERRACE DR death v a.m. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married þ 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify: WHITE 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DEPARTMENT STORE CLERICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELLA WINKLER EWELL THORPE 16, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 ROSEWOOD CR SHREWSBURY, PA 17361 CLIFTON CARR, III-SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/20/10 BALTIMORE, MD GARDENS OF FAITH Signature of Funeral Se 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, 21 6415 BELAIR RD BALTIMORE, MD 21206 enter the or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death st only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) END STAGE RENAL DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): the bunial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) detached 9 Unknown Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by a completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** Hospital: 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Nurse Practioner: To the best of my leavel death occurred at the time, date and place, and due to the cause(s) and internal as stated. (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

9

7:29

DECEMBER

JEAN RUOTOLO

32.

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Ruth A. Reynolds 2010° 12:17 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville Morningside House Assisted Living 5. Social Security Number If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex If Under 1 Year 8. Date of Birth Funeral 95 Days Min 1 □ M 2 🛛 216-05-6633 Yrs Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 222 any injury or other traumatic event. The Natural once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Parkville Maryland Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21234 8800 Old Harford Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fischer Body Keypunch Operator 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William J. Schehlein Lorraine H. Slitzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4002 Manor Caks Road, Phoenix, Maryland 21131 N. Guy Schehlein - Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State Dec. 22, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 21. Signature of Funeral Service License Name and Address of Facility Evans Funeral Chapel and Cremation Services -Parkville 8800 Harford Road, Parkville, Maryland 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, line. t and Death Immediate Cause (Final VEA Priysiciani D 101 disease or condition Medical resulting in death) to (or as a consequence Examiner 01/2016 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due ty (or as a concequence of) i signed by the attending physician and defeached for use as the burial-transit that initiated events to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mon 1 ☐ Yes 2 ☐ Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes To the Funeral Director: After this certificate has been s completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Hospital of 24 hours at Euneral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certified 0105 1, Da, Lintscam mo 210 90

DHMH 17 Rev 7/2009

State Registrar 32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

0.00.74		1- For State Control of Certificate Registrar		Reg. No.	20,5 6012
Physici	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day	3. Time of Death
Medical Exami	ner	Jessica Stewart		December 3, 201	10 0832 hrs
		Facility Name (if not institution, give street and number) Bon Secours Hospital	4b. City, Town, or Location of Death Baltimore	1 4C. (County of Death N/A
Funeral		5. Social Security Number 111 6. Sex 7. Age (In yrs. last birthday		s. 8. Date of Birth (MM/D	D/YYYY) 9. Birthplace (State or 12)
Director			Yrs. Months Days Hours Mir		Foreign
		Usual Residence of Decedent		[July 10, 1	
w any		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
Aaryland 28a-f show Latonce.	to	21,722	imore		1 X Yes 2 No
ie Mary or 28a	Director	10e. Street and Number 2312 Winchester Street	10f. Zip Code 21216		en of What Country? USA
0036 within 72 hours after death with the Maryland jone. her than "natural", or items 23a or 28a-f sho Me ikeal Ex. miner must be notified at once.			Was Decedent of Hispanic Origin? (S		4. Race - American Indian, 8lack,
eath v item:	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto		White, etc.
after d al", or	by F	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2X No specify:		Specify: black
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36 hin 72 c. than '	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	Ctudent		
5-0036 led within 72 Hygiene. other than the Me is a	Completed	-unk 2 years 17. Father's Name (First, Middle, Last)	Student 18.Mother's Name	e (First, Middle, Maiden S	Gurname) unk
21. be fill ntal I	-	Frank Byron Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Ethel 1	Neal	
D 21 should and Me 7 is ma	٩	19a. Informant's Name/Relationship (Type, Print) Brian Saunders/ Fiance 19b. Ma 231	illing Address (Street and Number or 2 Winchester St. 1 Penn Street Bal	Rural Route Number, City Balto., MD	7 or Town, State, Zip Code)
M 2 alth			position (Name of cemetery,		ocation - City or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite			other place F/H	/20 /10 Pol	timoro MD
		4 Donation 5 Nother Specify. in state ANd Cre 21. Signature of Furbral Service Licensee	2. Name and Address of Facility 05.	/20/10 Bal	- Funeral-Home PA
Balt permit. Depart Import		Ronald S. Wade Arector	140 N. Fulton Ave	01 Balto. MI	21217
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest, shoc	k, or heart Approximate Interval Between Onset and
/Medical examiner		Immediate Cause (Final disease a. Probable Cardiac A	rrhythmia		Death
		or condition resulting in death) Due to (or as a consequence of): b. Cardiomegaly With	Mild Myocardial F	ibrosis	
	ner	if any, leading to immediate Due to (or as a consequence of):			
0/	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (c. Due to (or as a consequence of):			
Tan e o'u'		d.		- <u>-</u> -	
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Box 687 e death certific the attending p	iciar	past 12 months? 4 Pregnant at time of death 5	Other (Specify)	ancy .	norm Buy rou.
Box 6876 The death certification the attending phenet for use as the	Physician/	1 Yes 2 No 9 V Unknown g Unknown		loo pidub	se contribute to the cause of death?
ires that the signed by I be detached	by F	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.		No 3 Probably 4 V Unknown
ds, l	ted			24a. Was an	24b. Were autopsy findings available
cords law requi	Completed			autopsy performed?	prior to completion of cause of death?
Vital Rechysician: The this certificate didirector, page		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 No	1 Yes 2 No
Vital ysician: his certiff director,	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpat	Othor	ng Home 5 Residen	ice 6 Other:
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should	⊢	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time	of Injury 28c. Injury at Work?	28d. Describe how injury	y occurred
ion ttendi death.	atio	Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		
Divisi spital or At ours after d neral Direct filled in by	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office building, etc.	28f. Location (Street and or Town, State)	d Number or Rural Route Number, City
Cospita I hours unera	ပျ	4 Homicide 29a. Certifier 4 Continue Physician To the best of my knowledge death or	coursed at the time, date and place, and	due to the cause(s) and	manner as stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation of the basis of examination of the basis of examination of the basis of examination of the basis of th			
To William	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
		anetz	O.C.M.E.	Dece	ember 4, 2010
~ 1		30. Name and address of person who completed cause of death (Item 23a)	O D		
LEDER			n Street, Baltimore, MD 2120	1 	
S Regis	tate trar	31. Date filed (Month, Pay Year) DEC 2 2 2010 Queen 5. Garden			
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DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland, Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLES, R DECEMBER 6:40 PM StANfield 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)

LA 6. Sex 1 🛂 🖟 2 🗆 F **Funeral** 216-70-7463 Days Hours Min 53 0370371957 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Easton MD Talbot 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA unkn. unkn 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 X No 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Crabber Fishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrnan Barbara Lecompte ပ Charles R. Stanfield Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
114 Juniper Ct., Glen Burnie, MD 21060 Tom Stanfield / Son Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/20/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Final Journey crem. 22. Name and Address of Facility
Maryland cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Myocardial Ph sician/ Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Set anything it hydrodals to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number NPI: 1 093030546 29d. Date signed (Month, Day, Year) DECEMBER, 15, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South GREENE STREET, BALTIMORE, MD 21201 MICHAEL CHUNG. 32. Registra 's Signalure State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19 Day 12 Month Physician/ 20^{Year}0 Colonel Lee Smith 6:20A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilcrest Hospice Baltimore CO TOWSON
If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign N. Counta) arolina 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours ₩ M2 DF 1276374936 212-32-9490 Yrs Director 74 Usual Residence of Decedent , or items 23a or 28a-f show miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2308 Ruskin Ave. 21217 S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 Never Married 2X Married <u>\$</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Specify: Black Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Schmidt Bakery 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Benjamin Smith Mary James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Georgianna Smith(wife) 820 Canton Ave., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Garrison Forest Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ renal disease Strage disease or condition edel Medical resulting in death) Due to (or as a consequence of): Examiner melli betes Sequentially list conditions, Examiner Due to (or so a consequence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death Unknown 9 Unknown been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by di SCASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No **Director:** After this certificate I Osteomye 25. Was case referred to medic Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined within 24 hours after To the Funeral Direc City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

701

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20, 2010 6:40 Р м Walter George Sandford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Villa Nursing Center Baltimore Catonsville 9. Birthplace (State or Foreign Country) England If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 - F Hours Min 549-24-5318 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Catonsville Maryland Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 210 Newburg Avenue 21228 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 \sum No 1942
If Yes, Give
Year or Dates. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or in any injury or other traumatic event, the Medical Examinance. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Hotel / Food Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Alfred James Sandford Annie A. Braidwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Newburg Avenue Catonsville, Maryland 21228 Debra MacKay, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 12/22/10 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Ligensee Thomas Gregor Pame and Address of Facility Of Maryland, Inc. 99 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ENO ACZHEIMERS YEARS OFMENTAR disease or condition resulting in death) STAGE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to Or as a consequence of: the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be execute physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 2 No 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed l director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural work?
1 Yes 2 No injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/22/2010 BDECKESS NO DAMIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 20, 2010 10:40AM BENJAMIN K SUGAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAL BALTIMORE Baltimore HOSPITAL OF Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 ☐ F Hours Country) 10071571917 93 Director 212-01-4617 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 7313 PARK HEIGHTS AVENUE, #302 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 XNo Specify. WHITE Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ LAWYER LAW injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SUGAR FANNIE KRULEWITCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau CAROL SUGAR/WIFE 7313 PARK HEIGHTS AVE, #302, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, cremetory or other place ARLINGTON CHIZUK AMUNO CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2010 BALTIMORE, MD 21. Signature of Funeral Syrvice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 MDPart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last sician and bunial-trans Due to (or as a consequence of): attending physician for use as the buna Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day signed by the a d be detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, tegni onaly Completed 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed 1 Yes 2 No 25. Was case referred to medical Division of Vital funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending or . .s after dea. .eral Director: Af 2 Accident Investigation 1 Yes 2 No 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral D completed filled in the filled i Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MBBS 00 December 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 AGHERA SINAI HOSPITAL OF >HAVAL 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Back 22 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death December 18, 2010 8:00 a.M Physician/ Solan Solan Keturah Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 12110 Shorefield Court Silver Spring 8. Date of Birth
(Month, Day, Yea
Sept • 4, 9. Birthplace (State or Foreign Country)

Jamaica 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Year) 1941 Days Hours Months 595-47-4406 69 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director 1 🗌 Yes 2 🛱 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o with Funeral United States 20902 12110 Shorefield Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items may injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Elderly Care Companion/Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Myrtella Anderson Vincent Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12110 Shorefield Ct. Silver Spring, MD 20902 Althea Solan (daughter) 20a. Method of Disposition

1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan Date 05. Clarendon, Jamaica 2011 Mitchell Town Fam.Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service Signature of Fineral day ice Licensee M00982 933 Gist Ave. Silver Spring, MD. 20910, U.S.A. 23a. Part 1. Enter the disease, or complications 1...t caused the leath. Do not enter the mode of dyin, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Du to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death the s 9 Unknown g | Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed certificate has been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one, Be Hospital: 1 Tes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D0A 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗵 Certifying hysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier December 21, 2010 10801 Lockwood Drive, Suite 310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, Maryland 20901 Jean Welsh, M.D. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TOEP Physician/ 25 DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lutherville Baltimore 11529 St. Davids Lane Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Age (In yrs. last birthday) Days 96 Hours Min. (Mooth, Day Year) New York 1 M 2 □ F 1914 130-01-6722 Yrs Director Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Lutherville Timonium 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 United States 11529 St. Davids Lane Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or lury or other traumatic event, the Medical Examir lury or other traumatic event, the Medical Examir þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Bank of Boston Banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kramer Henrietta Charles Stoeppler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod2109319a. Informant's Name/Relationship (Type, Print) 11529 St. Davids LaneLutherville Timonium Susan Saudek / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Dec 1 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 Donation 5 Other (Specify) 22. Nan@nemadrosomFamid Funeral Alternatives Signature of Funeral Service Licensee M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 10R11C 4ZARS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death ☐ Yes 2 L ☐ Unknown 2 No be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? AND Vaccular DISSAS 24a. Was an certificate has autopsy performe (Vasculas 1 Yes within 24 hours after death.

To the Funeral Director: After this certified completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check Singsone) Be examiner? Hospital Other: 4 Nursing Home ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Natural 2 Accid 27. Manner of Peath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔲 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) JOHN R. BURTOT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2 Year Physician/ 0353 AM RRSH December 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** BALTIMONE LARDIN HUSAIM Year If Under 24 Hrs Days Hours Min. 5. Social Security Number Date of bill (Month, Day, Yea 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Funeral Months Days Country) Virginia 1 M 2 F 70 Director 216-36-9941 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Examiner must be notified 1_Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a Funeral 21230 United States 3002 Huron Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "natural", or i any injury or other traumatic access. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Alford Packaging Lift Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy Lewis Stuples Nellie Nicely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Stuples /Wife 3002 Huron Street Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Dec 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2010 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives MO1443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician MYOCAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit HYPERTENSION 7-ean Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Year HYPERLIPIDEMIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBRIVASCULA 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗌 No ြုင ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific

DHMH 17 Rev 7/2009

State Registrar 3001

30. Name appraidiress of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatur

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Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Europel		Laurel Regiona. 5. Social Security Number	Hospita 6.Sex	T. Age (In yrs.	last birthday)	If Under 1		Inder 24 Hrs.	8. Date of Bir	th			lace (State or Fo	oreign
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	CV TO T		Josephine Siec		spouse	1	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Red Cedar Drive Burtonsville, MD 20866								
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	icensee /	M0077				Facility Avenue			arylaı	nd	20707	
П			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	caused the dea	th. Do not ente	er the mode o	f dying, suc	ch as cardiac c	or respiratory a	rrest,			Approximate Interval Between	en.
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o n	nding tth. : After e fune	cate	1 Natural 5 Pendir 2 Accident Investi	ng (Moi	nth, Day, Year)	injury	М	work? 1 ☐ Yes	1	200. 2000/120		,			
ISIC	· Atter	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	e of Injury - At h		eet, factory, o	office	- 7	28f. Location City or To			r Rural	Route Number,	
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	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical B	p Physician: To the Examiner: On the ba p Nurse Practioner	sis of examinati	on and/or inves	tigation, in my	opinion, de	eath occurred a	t the time, date	and place	, and due to	the cau	use(s) and manne	er stated.
	To th within To th comp	-	29b. Signature and title of certifie				29c. L	icense num	nber			te signed (N	lonth, L		
D			PULS	34			- 1	1000	67210		12	113)	lu		
	10/4		30. Name and address of person Rohit Khirb			m 23a) (Type, F Van Dus		ıd La	aurel,	Marylar	nd 2	0707			
	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 2 2010		Registrar's Sign										
			DEV SIS EVIO	Lenn	The Superior										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 19, 2010 4:30 P.M Marian Joyce Sweeney Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral (Month, Day Yo Year 1921 1 □ M 2 🛣 F Months Days Hours Pennsylvania Jan. Director 89 65-18-2286 Usual Residence of Decedent 10d. Inside City Limits shov 10b. County 10a. State 10c City Town or Location Examiner must be notified at death with the Maryland Director or 28a-f 1 Yes 2 No Fallston Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21047 1112 Sturbridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Executive Vice President Credit Card Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Martha Estelle (unk) Amos Ray Hinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1112 Sturbridge Road, Fallston, Maryland 21047 DECEMBER James P. Sweeney Husband 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Bel Air Memorial Gdn. 12/23/2010 Bel Air, Maryland Other (Spe 4 Donation 5 ify) 22. Name and Address of Facility 21. Sig McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1. Enter Onset and Death Immediate Cause (Final Physician CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). n any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 \(\sum \) Yes 2 \(\bar{X} \) No Month Dav Year Pregnant at time of death Unknown this certificate has been signed by the a ral director, page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 2 🗆 No 1 Tes MARIAN B B 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 X No ျှ 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred fter death. injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours

To the Funeral of completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and ardress of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

JACKIE JONES,

22

31. Date filed (Month, Day, Year)

CRNP

2300 DULANEY VALLEY RD.

MD 21093

TIMONIUM.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D20. December 2010 5:50 A M Η. Saley Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5608 Newington Road Bethesda Montgomery 8. Date of Birth (Month, Day, Year) June 2, 1922 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 🗆 M 2 🛛 F California Director 550-20-9501 88 June Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Bethesda ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20816 United States 5608 Newington Road items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married ģ 1 Yes If Yes, Give 2X No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Tax Preparer Tax Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Eugene Hyatt Katherine Grigg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lawson Smley/husband 5608 Newington Road Bethesda, Maryland 20816 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2XI Cremation 3 ☐ Removal from State inal Journey Crematory 12/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland wure of Funeral Service Lig Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M uanita M00957 Beverly L. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 years disease or condition Senescence Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, Examine Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death for in the past 12 month 1 Yes 2 No Month Year the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þ Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate Yes 2 XNo 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) မ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I

State Registrar

DHMH 17 Rev 7/2009

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30. Name and add

John E

29b. Signature and title of ce

ess of person who

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2 2010

M.D.

Yerg,

d cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

MD-D33554

5410 Connecticut Avenue, NW Suite 117 Washington, DC 20015

29d. Date signed (Month, Day, Year)

December 20, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ZOIO 833AM Joseph L. Siegel 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale FRANKLIN Square HOSPITal Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 13, 1929 Social Security Number 216–24–1333 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**X**XM 2 □ F Months Hours Balt. Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Baltimore Parkville 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 5 23a Funeral 3028 California Avenue 21234 America items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Completed by 1 Never Married 2 X Married 1 X Yes Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Bethlehem Elementary/Seconday (0-12) College (1-4 or 5+) Steel Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Siegel Mary Ida Blinken should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Juanita Siegel/ wife 3028 California Avenue Parkville, Maryland 21234 Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December Moreland Memorial 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State any injury or 4 ☐ Donation 🤌 ☐ Other (Specify) 22, 2010 Parkville, Maryland 21 Signature of Fu eral Service Lic 22. Name and Address of Facility Evans Funeral Chapel And Cremation Services 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac ArresT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Infarction myocardial Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury melliTus Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit iabetes and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 4 Pregnant 9 Unknown Pregnant at time of death 2 No the 9 Unknown Division of Vital Records, P.O. s been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vascular 1 Yes 2 No 3 Probably 4 Inknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto md 21237 9000 FRANKLin DR Square RICA BROWN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State racks Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death 1. Decedent's Name (First, Middle, Last) Pec TIMPSON Physician/ EORG Medical (if not institution, give street and number) City, Town, or Location of Death Examiner tonsville 8 Date of Birth 9. Birthplace (State 7. Age (In yrs. 83 last birthday) **Funeral** Country) 1 **X**M 2 □ F Director 10d. Inside City Limits Town or Location 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 No mor 10g. Citizen of What Country? 10e, Street and Number Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 1945 14. Race - American Indian 11. Marital Status Black, White etc. the Medical Examiner 1 Never Married 2 Married 0 þ 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Indus 15 Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ other traumatic al Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Vaughn & Greene Funera 5151 Baltmore National Signature of Funeral Service Licensee Funeral 21229 aughw Approximate Interval Between Onset and Death 23a. Part 1. Englished the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Immediate Cause (Final Chronic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months?

1 Yes 2 No
9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy fer obstructive Yes 2 🖳 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Other: 2 NH6 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ျ 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Suicide 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 36942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catoryville

DHMH 17 Rev 7/2009

State Registrar

TURAKHIA

1009 32. Registra s Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			- For Amend Items Registrar	29c,30 per	aryland Ver	d / Depr Cer	otment of tificate of	2010 and Death	Mental Hy	giene Reg. No.2010	40525	
	Physicia	n/	1. Decedent's Name (First, Middle, La	ast)		3			Date of De Month	ath Day Year	3. Time of Death	
Medical			Charles	lhom	as	1ho	mpsol		Nov	<u> २५ २०।</u>	O 11:40 PM	
	Examin	er	4a. Facility Name (if not institution, giv	re street and number)	11		4b. City, Town,	or Location of Dea	th	4c. County of De	ath ' \	
	Cunaval		5. Social Security Number 6.	O VVSVO Sex 7. Age		st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th 19 B	irthplace (State or Foreign	
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	×.		Usual Residence of Decedent							11/11/01		
	yland fshc ed at	ctor	10a. State 10b. County	,	10c. City	, Town or Lo	cation				10d. Inside City Limits	
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	ith th		10e. Street and Number	. 1			10f. Zip Code			10g. Citizen of What (Country?	
	ath w	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13 V	Vas Decedent of	1 d Hispanic Origin? (S	necify Yes or No-	14. Race - An	perican Indian	
ဖွ	er de or ite mine	by F	1 Never Married 2 Married	Armed Forces?	No		Yes, specify Cub	oan, Mexican, Puer	to Rican, etc.)	Black, Wh		
2-0036	2 hours aft "natural", edical Exal		3 🗌 Widowed 4 🗀 Divorced	If Yes, Give Year or Dates.		1	Yes 2 XN	o Specify:		Specify:	white	
5-(e flied within 72 hours after death with the Maryland tal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest g			(Give I	lent's Usual Occu	during most of wo	rking	16b. Kind of Busines	s Industry	
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	and 2 s Health em 27 i		Marshall Tho	mpson /s	Son	31	Manor	Rd E	1Kton	MD a	1691	
ore	re of		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3	Removal from State			sition (Name of natory or other pla	ice)	Dateunk	20c. Location - City	or Town, State	
Baltimore,	Page tment c tant: If jury or		4 Donation 5 ☐ Other (Spec		M	etro	Cremo	atary		130/10	MIS	
Bal	permit. Page Department Important: I any injury o once.		21. Signature Fun-1/ Service Licer	isee /	6	22	. Name and Addr	ess of Clifty	Midvo	May Do	JOSSIP, PA	
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~	h sician/		shock for heart failure. List only one cause on each line. Immediate Cause (Final disease or condition described by the cause (Final disease or condition described by the cause).									
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	d iii d	Examine	if any, leading to immediate cause. Enter underlying Cause (Disease or imitury)									
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	icate g physis the	1edi		d		· -						
89	certif	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnar	acv.		23d. Date of c	lelivery	
Box 687	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (specify)			Month	Day Year	
0	t the	Phy	9 Unknown Part II. Other significant conditions			daine in the c	ndorhing souss a	dues in Dest I				
σ.	Attending Physicians: The law requires that the death certificat arteath. arteath. arteath. After this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as the	þ	Part II. Other significant conditions	contributing to death bu	it not resu	nung in the u	nuellying cause g	ivei iii Fait i.		obacco use contribute	Probably 4 Unknown	
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၁၃	The law rate has by page 2 s	Completed							24a. Was auto	psy prior to death?	autopsy findings available o completion of cause of	
ž	sician: The certificate l rector, pag		25. Was case referred to medical	1		-		N (D) (O)	1 🗆 Yes		es 2 🗆 No	
/ita	Physician: this certificanal director, I	To Be	examiner?	Hospital:	t 0 🗆 [D/Outmation	t 3 DOA Ot	Place of Death (Che		dence 6 Other (Spe		
of\	g Phy er this neral c		27. Manner of Death	28a. Date of injur (Month, Day,	у [28b. Time of	28c. Inju	ry at		now injury occurred	ecity)	
on	endin eath. or; Aft ne fur	lical	1 Natural 5 Pending 2 Accident Investigation	on	rear)	injury	M 1	Yes 2 No				
Division of Vital Records, P.O.	or Atter de irrector by the post of the po	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ry - At hon (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tov	Street and Number or F vn, State)	lural Route Number,	
Ö	ours a eral D filled i		29a. Certifier 1 Certifying Ph	ysician: To the best of r	ny knowle	dae death a	occured at the tim	e date and place			stated	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di	Medical	(Check 2 Medical Exam		amination	and/or invest	igation, in my opin	ion, death occurred	at the time, date a	and place, and due to the	e cause(s) and manner stated.	
	with Total	_	29b. Signature and title of certifier	7 0 /	2		29c, Licens			29d. Date signed (Mor		
		10	· /m	salled	Cer	M		183		11.30.	10	
_			30. Name and address of person who Madhu S. Sachdev					ast. MD				
	Stat	e	Madnu S. Sachdev 81. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire A	/ /	,				
	Registra		U = 2 2 201	32. Registra	13.	MERK	1				.23	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DE Coth MELBA C. TURNER 2010 1:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
BALTIMORE 4b. City, Town, or Location of Death Examiner TOWSON GILCHRIST HOSPICE 9. Birthplace (State or Foreign Country LOUISIANA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. 1 M 2 X DEC. 18, Year) 1919 Director 90 454-18-3615 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified 1 Yes 2 X No HARRIS HOUSTON TXþ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral filed within 72 hours after death with USA 77017 915 AUBERT AVE items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, ō Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 XNo Specify. Specify "natural", 3 √ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOSPITAL WARD CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MOLLY RAY JULIUS NISSEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 ORBITAN RD BALTIMORE, MD 21234 19a. Informant's Name/Relationship (Type, Print) 3405 ORBITAN RD GERALD TURNER-SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/21/10 HOUSTON, TX FOREST PARK 21. Signatur Funer Service License 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final ₹tıysiciaπ/ Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for se a consequence of: Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 7 9 Unknown detached ils certificate has been signed by a director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate I 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral! 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident 2 🕽 18C6mber 4,200 Νo bathroom Investigation untra 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, m City or Town, State) ASSISTED nome Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) DEC 2 2 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:13 А. м Joseph J. Velenovsky December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Charlestown Nursing Home Catonsville 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min. (Month Day 1 X M 2 ... T914 Maryland 220 05 7935 96 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 1 🗌 Yes 2 🔀 No Baltimore Catonsville Marvland 10f. Zip Code 10e, Street and Number 10a, Citizen of What Country? Funeral 715 Maiden Choice Lane 21228 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Yes, Give Specify Specify. 3 X Widowed 4 Divorced White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retired Chemist Chemica1 vears Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Joseph John Velednovsky, Sr. Mary Frances Smetana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1491 Falcon Nest Cathy Strickler / Niece Arnold, Maryland 21012 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State 12/27/2010 Elkridge, Maryland Meadowridge Mem. Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ediate Cause (Final 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, Approximate Interval Between Immediate Cause (Final Onset and Death Physician COKS disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 D 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 🗀 Yes 2 No 3 Probably this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an completed filled in by the funeral director, page 2 autopsy perform death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After work? injury Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 20 K 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice In Cathonsville MD 32. Registrar Signatu State Registrar

			FOI	epartment of Health and Mental Hy Certificate of Death	ygiene Reg. No.		
Г	Physicia Medic		1. Decedent's Name (First, Middle, Last) Ruber + M. Wilso.	2. Date of D	Death 3. Time of Death 2 Day 2 Year 0 430 PM		
	Examin		4a. Facility Name (if not institution, give street and number) Riva Terrace V	4b. City, Town, or Location of Death Arnold	4c. County of Death Anne Arundel		
	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	ay) If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. Mar • 2	9. Birthplace (State or Foreign Country) Montana		
	Maryland 28a-f show atified at	Director		Annapolis	10d. Inside City Limits 1 □ Yes 2 ဩNo		
	with the s 23a or 3	Funeral Di	10e. Street and Number 105 Lee Drive	10f. Zip Code 21403	10g. Citizen of What Country? United States		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1943 If Yes, Give Year or Dates 1946	 Was Decedent of Hispanic Origin? (Specify Yes or Not If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 Ŋ No Specify: 	14. Race - American Indian, Black, White, etc. Specify: White		
Baltimore, Maryland 21215-0036	ithin 72 hou ene. • than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	ecedent's Usual Occupation live kind of work done during most of working e. DO NOT use retired) Program Analyst	16b. Kind of Business Industry Federal Government		
and 2	ntal Hygin red other s event, t	l as l	17. Father's Name (First, Middle, Last) Thaddeus Constantine Wilson	18. Mother's Name (First, Middle Ethel Hannifi	e, Maiden Surname)		
Maryl	and 2 should t Health and Me tem 27 is mark			19a. Informant's Name/Relationship (Type, Print) 19b. M	Mailing Address (Street and Number or Rural Route Numb Lee Drive, Annapolis, Ma	ber, City or Town, State, Zip_Code)	
more,	Page 1 and of the net of the net. If item by or other of the or other or ot	Ì	1 Burial 2 X Cremation 3 Bernoval from State cemetery, of	isposition (Name of crematory or other place) Crematory Inc 12/21/2010	20c. Location - City or Town, State Baltimore, Maryland		
Balti	permit. F Departm Importa any inju	Ì	21. Signature of Funeral Service Licensee Alyson K Taylor	,	n Society of Maryland		
jii ma	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiac or respiratory a	arrest, Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
*	uted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events				
092	cate be executed physician and s the burial-transi	edical E	resulting in death) Last Due to (or as a consequence of): d.				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year		
ds, P.O.	v requires that th s been signed by should be detac	by	Part II. Other significant conditions contributing to death but not resulting in the	, , ,	tobacco use contribute to the cause of death? Yes 2 \nabla no 3 Probably 4 Unknown		
Division of Vital Records,	sician: The law requi certificate has been irector, page 2 should	Completed		per	s an copy formed? s 2 No 1 Yes 2 No 1 No 1 No 2 No 2 No 2 No 2 No 2 No		
Vital	Physician: this certifical al director,	To B	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		sidence 6 Other (Specify)		
on of	I or Attending P after death. Director: After t I in by the funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		how injury occurred		
Divis	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page		4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)		
	To the Hospital within 24 hours a To the Funeral Completed filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal only one) 2 Medical Examiner: On the basis of examination and/or in Certifying Nurse Practioner: To the best of my knowledge.	ivestigation, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and manner stated.		
	With Con.		29b. Signature and title of certifier	29c. License number 015872	29d. Date signed (Month, Day, Year) Dec 21, 2010		
_	2+1		30. Name and address of person who completed cause of death (Item 23a) (Typ	DISTA- DISTA- DING Slub Ju	Lo y 2 106/		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Michael Thomas Ward Jr 2010 December 7,2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 10402 Haliard Street Cheltenham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1986 **Funeral** Days Hours 1X M 2□ F 23 December 213-27-4010 Washington DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show e notified at 10b. County ty⊡Yes 2 No Directo Maryland Prince George's Cheltenham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e iral", or items 23a Examiner must b 10402 Haliard Street United States 20623 Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Y Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates er than "nature the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) United States Army Motor Transport Operator Twelfth None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth Be Juanita Madaline Scott Michael Thomas Ward Sr ျ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10402 Haliard Street, Cheltenham, Maryland 20623 19a. Informant's Name/Relationship (Type. Print) Michael Thomas Ward Sr/Father permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 7 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State December 15 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of FacilityRobert G Mason Funeral Home Inc 21. Signature of Funeral Service Licensee Donald R. Gray 1661 Good Hope Rd SE Washington DC 20020 23a. Part1. Enjer the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or contion **Physician** Due to r as a consequence of): disease or con resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-trai Due to (or as a consequence of) physician the burial Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the detached 9∏Unknown 9 ☐ Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 2 No 3 Probably 4 Unknown 1 ☐ Yes been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has I performe 22 No certificate 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ٩ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 24 cmg 27. Manner of Death Certification: or Attending lf at Injury 1 Natural 5 Pending himes a To the nospinal within 24 hours after death.

To the Funeral Director: Af Pec ember 72010 2010 M 1 = 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2010 M 1 ☐ Yes 2 ☑ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State] 0402 Haliard St., Cheltenham, MD 20623 4 Homicide home To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVATOR 31. Date filed (Month, Day, 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Year Month 01:00 PM Osborne G. Williams, III 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day Year)
OCt. 08,1941 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Hours Mary land **Director** 219-38-5534 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 ☐ No Maryland | N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Wyanoke Avenue Apt. 504 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates. 3 ₺ Widowed 4 □ Divorced Specify.B.lack Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel 5th grade Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Osborne G. Williams, Jr. Edna Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6407 Hilltop Avenue Baltimore, MD 21206 Anne R. Green/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery | 12/23/2010 | Baltimore 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, MD 21215 20a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence of) **Examiner** chronic lymphocytic leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence on that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury 28b Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral place on pleted filled in by the funeral completed filled in by the funeral place. Natural (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1. 🚉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) rough 2438946 2010

DHMH 17 Rev 7/2009

State

Registrar

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Union Memorial

Balhmore

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

MC ZAYAN

MANSOOR
31. Date filed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wirsing Dec. 2010 Mildred Marie 3:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore City 902 South Clinton Street Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 K Months Days Hours March Day Year 1945 Director 65 212-42-6932 Maryland Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City N/A 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be by Funeral 21224 United States 902 S. Clinton Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. 1X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government General Service Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Catherine Moltz ٩ Charles John Wirsing, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health in Item 27 i 7834 Lockwood Road Dundalk, Maryland Department of Health Important: If item 27 any injury or other tronce. Robert Louis Wirsing (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12/23/2010 Parkwood Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
Dundalk, MD 21222 21. Signature Funeral Service Licenses 7922 Wise Ave. Dundalk, MD 23a. Part 1. Enter tile/ lisease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List in y one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it cay, a conditions cause. Enter Underlying Cause (Disease or iinjury Due to for as a gansecuring of that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETER MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 2. No Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Mertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b. Signature and title

State Registrar DEC. 20, 2010

STE

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:16 PM WOODIN DECEMBER NENA 18 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 26,1941 Maryland Director 216-40-0854 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f shorn 1 ☐ Yes 27 No Director Baltimore Co. MD <u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code must be 21224 United States 7603 Poplar Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married ō 1 ☐ Yes 2 文No Specify: White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Travel Coordinator Travel 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mack Fennell Dorothy Bourdon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S Pasadena, Maryland 21122 7961 Hunt Ridge Road Health em 27 i Milo Earles (Daughter) Department of Healt Important: If item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 12/21/2010 Towson, Maryland 4 Dentation 5 Cher (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, neral Service Licenses 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) MYPOXIA /Medical Due to (or as a consequence of) Examiner DIFFERENTIATED NON SMALL CELL LUNG CANCER FOORLY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of, The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Mopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 No 2 Accident investigation Director: 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2

10

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CHRISTOPHER KANAKRY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

D0070620

29d. Date signed (Month, Day, Year)

DECEMBER 18,

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Certi	ficate of	Death		Reg. No.	UHL	1000	
П	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	Time of Death	
	/Medi		Edna Willces					Decem	per 19	11 0102	7,30 6,11	
7	Examir	ner	4e. Facility Name (If not institution, give stre Villa Rosa Nursi				4b. City, Town, or Bowic			of Death ICE Geo	rges	
			5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	f Under 1 Year					(State or Foreign	
•	Funeral Director			2□X 99		lonths Days			911	Country) NY	State of Poreign	
	yland		10a. State 10b. County	10c. Ci	ty, Town or Locati	ion				10d. Ir	side City Limits	
	Man B-fah	ģ	10a. State 10b. County 10c. City, Town or Location Crofton Crofton								□Yes X □No	
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?		
	ath w	la	2131 Davidsonvil	le Road		211	14		USA	1		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinal must be notified at once.	by Funeral	11. Marital Status 12. 1 □ Never Married 2 □ Married 3 □ Married 4 □ Divorced	Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates:	If Ye	s Decedent of es, specify Cub Yes 2⊠No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Blac Δ f	e - American Inck, White, etc. Crican 'Amer.	dian,	
5-0	72 honatur natur dical	Completed	15. Decedent's Educati (Specify only highest grade co		16a. Decedent	t's Usual Occu	pation during most of wo	rkina		usiness/Industry	,	
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and	d be finital hed of	Be	James White				Jennie	me <i>(First, Middl</i> e, White	Maiden Suman	ne)		
<u></u>	should nd Me mark imatic	ဥ	19a. Informant's Name/Relationship (Type,	Print)	19h Mailing A	ddress (Stree	t and Number or R		r City or Town	State Zin Code	a)	
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altimore, Maryland 21215-0020	ages 1 a ant of Hea t: If Item y or othe		20a. Method of Disposition 12 Burial 2 □ Cremation 3 □ Rem	oval from State Hi	Place of Disposition completery, cremator 11side	on (Name of ory or other pla Cem.	ice)	12/28/		City or Town, S		
	nit. Partme ortan injur		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Linese	-		ame and Addr		2010				
<u>~</u>	permi Depa Impo any it) He	-	512	6 Bela	air Rd,		D 2120	F.Svs, 6-5105	PA	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
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68760,	eath certificate be executed attending physician and I for use as the burial-transit	edical	Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequen	ce of):						
×	entific ling p	2	d									
o n	The law requires that the death cate has been signed by the attencage 2 should be detached for us	Physician.	- u					7				
o.	he de / the a	ysic	Part II. Other significant conditions contrib	uting to death but not res	ulting in the under	lying cause gi	ven in Part I.	23b. Did t	obacco use co	ntribute to the	cause of death?	
Ţ.	that led by deta	P P	Dabetes Melli	tus				1 🗆 ነ	'es 2□No	3 🗌 Probably	4 Unknown	
Vital Records,	n sign	od by						24a. Was			topsy findings	
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- -	ysician: ils certific i director,	2	examiner? 1 ☐ Yes 2 ☐ No Hosp	ital: 1□Inpatient 2□	ER/Outpatient 3	BD DOA Ot	her: 4 Nursing H	lome 5 🗆 Resid	ence 6 □Oth	er (Specify)		
_	ding Phy h. After this funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe h	ow injury occur	red		
<u> </u>	Attending Physician: r death. sctor: After this certific. by the funeral director.	cati	2 Accident investigation				Yes 2 No					
DIVISION	talor Atra after or al Directed in by	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						treet and Numb n, State)	er or Rural Rou	te Number,	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	edicai	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	n: To the best of my known on the basis of examinat and manner stated.	wledge, death occition and/or investi	curred at the ti gation, in my	me, date and place opinion, death occu	, and due to the or rred et the time, o	ause(s) and ma late and place,	anner as stated. and due to the c	ause(s)	
	To the To the Comp	M	29b. Signature and title of certifier			29c. Licen:			_	d (Month, Day,		
			Voratty Se	Sign		DO	553337	-	Decem	ber 20	6105,	
•			30. Name and address of person who compl	eted cause of death (Item		t)	053337 rue St		3 11		٨	
	4		Dorothy Seaymi		SONHI	n Hue	rue St	e Zo3 F	alth	ove, Mic	15150d	
	Stat	е	31 Par (iled (Month) Par Year)	22. Registrar's Signa	ture							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 35AM 4 tescia 2010)ccember Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Glen WASHIN timere GION nedou Cent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month. Day. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) 1 M 2 X F Country) Director 214-64-0528 56 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2X No MD Anne Arundel Severn 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 1450 Watts Ave 21144 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Force or j 1 Never Married 2 X Married ☐ Yes 2 X No þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Black 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Care 12th grade Nursing Home na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Archie P. Jones Betty Artis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other Maurice Wood-Husband Watts Ave. Severn, Md 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Ridae 12/31/2010 Pikesville, Md 22. Name and Address of Facility 21. Sign ure of Funeral Service Licensee Wes Ma68hwE Baltimore, Md ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part Enter the d Approximate or heart failure Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a nonsequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Pregnant at time of death Month Day Year been signed by the should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 1 🗌 Yes 2 No Other: 1 Inpatient 2X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this n 24 hours after death.

Pe Funeral Director: After the oldered filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d 550 31. Date filed (Month, Day, Year) 32. Registra 's Signature State 2010 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0535 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frank Т. Williams, Jr Month Decembe 2010 2:18AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital 61 Baltimore Baltimore Citi 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days XXM 2 DF Months Hours Min. 5-26-1951 Director MD 216-54-2138 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits MD 1X Yes 2 ☐ No na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral apt 915 3800 W. Belvedere Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates. 1 Yes XXNo Specify. USA Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of Working life. DO NOT use retired) unk (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 11th grade Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) ٥ Frank T. Williams, Sr Nellie Parker 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3939 Frisby Avenue Tawanda Williamson Baltor <u>Md 2128</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) 12-Greenmount -10 Balto, MD 21. Signatur of Funeral Servi e Licensee 22. Name and Address of Facility March East F/H 1101 Ε. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) irrhosis years Medical Due to (or as a consequence of): Examiner monthe Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, pag 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours after To the Funeral Direct Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature RES -000 December 15,2010 7 ompleted cause of death (Item 23a) (Type, Print) Sinai Hospital eamrat Adhanom M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Day Bernard A. Williamson-Taylor 17 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Johns Hopkins at Bayview Baltimore na 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F (Month, Day, Year) 4-9-1941 West 217-68-2765 Director 69 Africa Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Funeral Director MD Baltimore na 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5602 Seward Avenue 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 Narried 1 Yes 2 No If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Alban Tractor Co. Elementary/Seconday (0-12) College (1-4 or 5+) Stock Auditor years traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ <u>Rowland Wiiliamson-Taylor</u> Elsie Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife D partment of Health <u> Harriett Williamson-</u> 5602 Seward Avenue MD 21206 othe Balto 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Garden of Faith Date 20c. Location - City or Town, State ò 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Rosedale, MD 12-4-2010 injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee March F/H 22. Name and Address of Facility East a y 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause, n Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) rosc ero Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit pertension that initiated events resulting in death) Last Due to rus a consequence of Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 욘 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending injury 1 Yes 2 No М Accident Investigation 2 Accident
3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, in 24 hours after deau...
the Funeral Director: After th

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29c. License numbe 29d. Date signed (Month. Day, Year, 20676 November

State Registrar

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1.32A M DECEMBEZ PA 2000 Wolfe Gladys Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County County of Death **Examiner** BURNIE HUDA BUTIMBER WASHINGTON MEDICAL CENTER MEN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Days Hours Min. March Day Year 1930 KV 311-30-0093 80 Yrs. **Director** Usual Residence of Decedent 28a-f shov 10b. County Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 USA 207 Winston Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Mary Smith Cloyd Blankenship 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Winston Road, Pasadena, MD 21122 Earl W. Wolfe (spouse) Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Dec. 22 2010 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadowridge Cemetery 21. Sign 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bause on each line. 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CAZDIO MYO F disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy Year 5 Other (specify) Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ြု After this . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)
DeCember 192016 Signature title of certifie 1345 149 completed cause of death (Item 23a) (Type, Print) Glen Burnue MD 20161 d address of person who 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DAT **Physician** DECEMBER 2010 4a. Facility Name (If not institution, give street and number) 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Northwest Hospital Baltimor Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. 14, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** GOUDTRY) 219-18-9407 1 ☐ M 2 ☑ F 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State MD Baltimore Pikesville 1 TYes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 r than "natural", or items 23a or the Medical Examiner must be 7233 Phal Farm Way Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Intent 27 Is marked other than "natural", or ite nay or other traumafic event, the Medical Examine. Iny or other traumafic event, the Medical Examine. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Samuel Reddy College (1-4or 5+) 1 Yr Elementary/Secondary (0-12) School Cook 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howell General Purvis Effie 19a. Informant's Name/Relationship (Type. Print)
Verely Karim/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7233 Phal Farm Way Pikesville, MD 21208 Department of Health a Important: If Item 27 Is any Injury or other trauonce. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Removal from State 12/28/10 Arbutus Mem Pk Arbutus, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 ullel 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS SECONDARY TO DECUMITUS /Medical Due to (or as a consequence of) Examiner METRIS CLIL
Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 I Inknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed DEMENTA page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy perform certificate 2 N No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 XInpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation n 24 hours after death.
the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hot To the Fune completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mehlam. D

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John DER

32. Redistrar's signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ WONG 11:25 December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Nane Baltimore Citx Good Samaritan Maspita If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day) Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Feb. 20,0 eac 937 215-04-2546 China 73 **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is anarked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore MD Nane 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6116 Edlynne Road 21239 China 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Chinese If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) At Home Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 5 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Wong Unknown Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Si Cheng Chen/ Son 6116 Edlynne Road, Baltimore, MD 21239 20b. Place of Disposition (Name of Lorganiery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 21, 2010 Cemetery of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. P. rt. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ diseate or condition resulting in death) UIN KNOWIN Medical Due to (or as a consequence of) Examiner unknach Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown ☐ Yes _ _ ☐ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 2

Mekonen M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Exasu Mekonen, M.D

December 16, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 1 0

		•	For State Registrar	Cei	rtificate of E	Death	Re	g. No. 2010	40540
	Physicia		1. Decedent's Name (First, Middle, Last) Charles Albert Wunder				2. Date of Death Month December	Day Year	3. Time of Death 6:02 P .M
	Medic Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice Center		4b. City, Town, or	County			
	Funeral Director			(In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 23, 1	9. Birth 933 Balt	place (State or Foreign try) Linore, MD.
	Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore County	10c. City, Town or Lo Luthervi	lle				10d. Inside City Limits 1 ☐ Yes 2 🛂 No
:	with the s 23a or ust be n	Funeral D	10e. Street and Number 11920 Meylston Drive		10f. Zip Code	21093	11	Og. Citizen of What Cou United Sta	
3	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If time IZ1s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evaraged Forces? 1 Yes 2 Never Married 1 Yes, Give 1 Year or Dates.	No I	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔼 No		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W.	
	thin 72 hou ene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-	(Give	dent's Usual Occupi kind of work done o DO NOT use retired) INSULANCE	luring most of work	ing	16b. Kind of Business Ir Insura	-
7	be filed wi ental Hygie ked other ic event, tl	To Be (17. Father's Name (First, Middle, Last) Charles Beauregard Wunder			18. Mother's Nam	e (First, Middle, M ne Lucil)		
i i i	d 2 should alth and M n 27 is mar er traumat		19a. Informant's Name/Relationship (Type, Print) (Wife Mrs.Shirley (nee Apple)Jenk) 19b. Maili Ins 1192	ing Address (Street a 0 Meylsto	and Number or Rura on Drive	al Route Number, C Luther	City or Town, State, Zip	Code) land 21093
	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 🖁 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemeter, cre Evans Fune Cremation	osition (Name of matery or other place ral Chapel Services, I	and Tues nc. Dec.2	day, 1,2010	20c. Location - City or T (Harford Forest Hil	county) County) 1,Maryland
Š	permit. Departr Imports any inju	ļ	21. Signature of Funeral Service Licensee Jeffrey L.				uneral & Conium,Mary	remetion Cente land 21093-2	r, P.A. 2215
·P	hysician/		23a. Pert 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	the death. Do not ent	ter the mode of dying		or respiratory arres	st,	Approximate Interval Between Onset and Death
1	Medical Examiner		resulting in death) Due to (or as a	consequence of):					7,5,7
	ecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):						
3	mcate be executed by physician and as the burial-transit	Medical	d						
		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnanc Other (specify)	y		23d. Date of deliv Month	very Day Year
	signed by	δ	Part II. Other significant conditions contributing to death but	It not resulting in the	underlying cause giv	en in Part I.		acco use contribute to to	he cause of death?
	Attending Physician: The law requires that the death cer at death. Adeath. After this certificate has been signed by the attendies the funeral director, page 2 should be detached for use	Completed					24a. Was an autops perforn 1 \(\sum \) Yes 2	y prior to co	opsy findings available ompletion of cause of
_ :	ysician: I is certifica director, p	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpatie		Othe	ace of Death (Chec	k only one)		<i>II</i>
5	Attending Physer death. ector: After this by the funeral di	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Inpatie 28a. Date of injur (Month, Day,	nt 2 ER/Outpatie y 28b. Time o year) injury	of 28c. Injun work	y at	28d. Describe how	nce 6 Other (Specifing Notice of the Notice	A) 1152 316 A
	al or Attendii s after death. il Director: Al ed in by the fu	Certificate:	3 Suicido 6 Could not be	ry - At home, farm, str (Specify)	reet, factory, office		28f. Location (Str City or Town,	eet and Number or Rura State)	l Route Number,
	To the Hospital or vithin 24 hours after To the Funeral Director Completed filled in the filled in t	Medical	29a. Certifier 1 Certifying Physician: To the best of r (Check only one) 3 Certifying Nurse Practioner: To the basis of ex	amination and/or inves	stigation, in my opinio	on, death occurred a	t the time, date and	d place, and due to the ca	ause(s) and manner stated.
À	To T		29b. Signature and title of certifier	MD	29c. License	0 6 3 S	29	9d. Date signed (Month,	Day, Year)
1)		30. Name and address of person who completed cause of de Cauva Part et 6701 N				MD 21	284	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registral		1			, .	

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0-09671 Frank Joseph W	/ehe		e or Print in ite of Marylan						egible. 🤈 🛭	10 605	541
Tank Joseph V		1- For State Registrar	ite or iviaryian			of Death	iu ivierita		Reg. No.	, , , , , ,	
Physici	an/	1. Decedent's Name (First, Middle	,Last)					Date of De Month	Day Yea	3. Time of Dea	th
Medical Exami	ner	Frank Joseph						Decemb	er 15, 2010	1645 nrs	
		4a. Facility Name (if not institution 1904 Cosner Road	, give street and numb	per)		4b. City, Town, o	or Location of I	Death	4c. County of Harford	of Death	
Funeral		5. Social Security Number 6	6. Sex 7.	Age (In yrs. la	ast birthday)	If Under 1 Ye	ar If Under 2	24Hrs. B. Date of B	Birth (MM/DD/YYYY	9. Birthplace (State or	
Director		215-54-2770	1 <u>X</u> M 2 <u>F</u>	61	Y	rs. Months Da	ys Hours	Min. Oct.	6, 1949	Foreign Country) Maryland	
>		Usual Residence of Decedent		Idon Oite	Town or Loc	oti				10d. Inside City	v Limite
nd how any cc.		10a. State 10b. County Maryland Harf	ord							1 Yes 2	
Maryland 28=-f show d at nnce.	윉	10e. Street and Number	Ora	FC	rest F	10f. Zip Code			10g. Citizen of Wh	nat Country?	
r death with the Maryland nr items 23a nr 28a-f sho must be notified at ance.	Director	1904 Cosner Ro	ad			2105	0		United S	tates	
h with	era	11. Marital Status	12. Was Deced			Vas Decedent of H Yes, specify Cuba		? (Specify Yes or Nuerto Rican, etc.)	lo- 14. Race White	- American Indian, Blac e. etc.	ж,
r deat nrite	Funeral	1 Never Married 2 Mar	1 Yes	2 XX No				,			
s afte ral",	à		rced If Yes, Give Year or Dates:		1_	Yes 2 X N		4 -54		White siness/Industry	
hour "natu	fed	15. Decedent's Education (Speci Elementary/Secondary (0-12)	College (1-4			most of working lif			TOD. KING OF BU	silless/illidustry	
21215-0036 Mental Hygiene. marked other than "natural", ur items 23a nr 28a-f sho e event, the Medical Examiner must be notified at nace	Completed	12	2	(O ()+)	Welde	er			BAE Sy	stems	
5-0 led w Hygie othe		17. Father's Name (First, Middle, I					1B.Mother's	Name (First, Middle	, Maiden Surname)	
121 be fi ental	Be	Frank William						el Bryant			
	은	19a. Informant's Name/Relationsh			31	- ,				n, State, Zip Code)	- 4
re, MD 2: 1 and 2 should If Health and M If item 27 is m		Heather Travagl 20a. Method of Disposition	ini / Daug			Wild Gi		ourt Colu		21044 City or Town, State	
ore, selan of Heal		1 Burial 2 X Cremation	3 Removal from	n State	crematory or	other place) neral Ch	anol]	Dec. 18,	20c, Location	City of Town, State	
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental I ant: If iten 27 is marked ar nther traumatic event,		4 Donation 5 Other Spe		LV	Bel A	ir		2010	Forest	Hill, Mary	land
Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Important: If item 27 is injury an rather traumat		21. Signat of Funeral Service L	211		22 E	Name and Addre	ss of Facility eral Cl	Hapel & C	remation	Service-Be	l Ai
Physician		23a. Part I. Enter the disease, or of failure. List only one cause of		ised the death	. Do not ente	r the mode of dyin	g, such as car	Forest H diac or respiratory a	rrest, shock, or he	A r Between On	Interval set and
/Medical xaminer		Immediate Cause (Final disease	a. Hypertensive	Atheroscl	erotic Car	diovascular D	isease			Death	ו
, carring		or condition resulting in death)	Due to (or as a c	onsequence o	f):	<u> </u>					
	ايرا	Sequentially list conditions,	b. Due to for ea a c	NEWS TA	n:						
	ië	cause. Enter Underlying Cause	C. Driese for as a c	United States	-1					1	
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence o	f):						
60, ate be executed obysician and			d								
oe exe cian a	Medical	UNPENDED	AMENDED								
60, ate be ohysical	S S	IF FEMALE:	23c. If yes, ou	tcome of preg	nancy				23d. Date of	delivery	

Division of Vital Records, P.O. Box 687.

The the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death

The Runeral Director. After this certificate has been signed by the attending ple completely filled in by the funeral director, page 2 should be detached for use as in Medical Certification: To Be Completed by Physician/i

UNPENDED	AMENDED	
IF FEMALE:	23c. If yes, outcome of pregnancy	23d. Date of delivery
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	cy Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Chronic alcohol abuse		1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy findings availal prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
25. Was case referred to medical	26. Place of Death (Check or	nly one)
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing	Home 5 Residence 6 ✔ Other: Scene
27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investiga	(Month, Day,Year) 1 Yes 2 No	28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

2Bf. Location (Street and Number or Rural Route Number, City or Town, State)

December 16, 2010

29d. Date signed (Month, Day, Year)

Melissa Brassell, MD 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

29a. Certifier 1 (Check only one) 2

3 [

Masse 30. Name and address of person who completed cause of death (Item 23a)

6 Could not be determined

Assistant Medical Examiner

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc.

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bernard Young Sr. Physician/ December 19,2010 11:00 pm Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Gilchrist Hospice If Under Social Security Numbe Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 212-34-0387 Months Days Hours 73 MD Director 05/15/1937 Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director Harford Edgewood MD NO Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 Funeral 316 Turquoise Circle items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ō ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Officer Law Enforcement 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Genevave Kent 0 Robert Young ^{19a.} Informant's Name/Relationship (Type, Print) **Eunice Johnson / Daughter** 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State Zip Code) 316 Turquoise Circle, Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/23/2010 Woodbine, MD Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 wirste 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 20 ph disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? autopsy After this certificate 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? a 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify) 10501 (C ပ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 ___vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated o, y one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

670

00071287

St. Suite 4105 Balti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9; 10 P M Berjamin Anderson December 2010 Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death Examiner 4b. City, Hospice @ NW Randallstown Baltimore If Under 1 Year If Under 24 Hrs. ln yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Yea VA **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic account. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD DWINGS Mills Saltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Avatar 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Acme Baken Kaker grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mandie Richardsor Walter Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andersu Lane Owings Mills, MD 2117 Avatar 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Ling Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1

Burial 2 ☐ Cremation 3 ☐ Removal from State WindsorMill, MD 28 2010 4 ☐ Donation 5 ☐ Other (Specify) c. Greene Funeral services Valiann Signature of Funeral Service Licensee 22. Name and Address of Facility aug 8728 Liberty Handall Stann MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic prostate cancer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Pregnant at time of death Yes 2 No the a 9 Unknown g 🗌 Unknown completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🗖 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Dother (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MS Rajupalne M. D. 12/23/10 DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.S. RYMPAKH, M.D. 2835 Smin AV-5-7 2835 Sming AV. 5-203, Baltimore, MD. 21209 31. Date filed (Month Day Year) 32. Registra/s Sign

State Registrar

			Please	Type or Print in						
			For State Registrar	State of Maryla		artment of tificate of		nemai mygier Reg.	21111	40544
	Physicia Medic		1. Decedent's Name (First, Middle, Las	Anthony				2. Date of Death	Day Year 7010	3. Time of Death
	Examin		4a. Facility Name (if not institution, give	11 .		4b City, Town	, or Location of Death		4c. County of Death	
- September 1	Funeral		5. Social Security Number 6. S		rs. last birthday)	If Under 1 Yes		8. Date of Birth	9. Birth	place (State or Foreign
	Director		057-58-/237 1 Usual Residence of Decedent	□ M 2 🕶 F	38Yrs.	IVIOITIIS Day	75 110015 111111	(Manth, Day Yea	1972	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	yland if show ed at	ig	10a. State 10b. County	10c.	City, Town or Loc	cation	. 11			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Mar or 28a- o notifi	Director	10e. Street and Number	nore 10	wing	10f. Zip Cod) <i>ì </i> <u> </u>	10g.	Citizen of What Cou	
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral	4218 Winfield	2 Drive		2	-1117		USA	
(0	or iter	by Fu	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	1	f Yes, specify Co	of Hispanic Origin? (Spouban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
003	urs aftu tural", al Exar	ted k	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		I ☐ Yes 2 🗹			Specify: 3/	ack
21215-0036	n 72 ho an "na Medic	Completed	15. Decedent's Elementary/Seconday (0-12)	ade completed) College (1-4 or 5+)	(Give I	dent's Usual Oct kind of work dor O NOT use retire	ne during most of work	ring 16b	. Kind of Business Ir	ndustry
121	led within 'Hygiene. other thar ent, the M	ادها	12		In to	ake c	Officer	Timat Middella Maid	a / timo	re City
lanc	ild be filed Mental Hy narked oth atic event	To E	17. Father's Name (First, Middle, Last)	ccins			Mary 18. Mother's Nam	ne (First, Middle, Maid An tho	on V	
Maryland	shou and is m		19a. Informant's Name/Relationship	Print)		ng Address (Stre	eet and Number or Run	al Route Number, City	or own, State, Zip	Code)
	f Heal f Heal item		20a. Method of Disposition		b. Place of Dispo			Date 200	Location - City or T	own, State
Baltimore,	0 4 ×		1		King C	natory or other p	12.6	7-2010 K		ic mo
Bal	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licens	D. I.	8	2. Name and Add	dress of Facility		ore Funeral	
			23a. Part 1. Enter the disease, or comshock, or head failure. List only company to the company of the company o	plications that caused the cone cause on each line.	death. Do not ente	er the mode of o	lying, such as cardiac			Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. End-Star		risease				Onset and Death
-	Examiner		Sequentially list conditions,	b ————	sequence on.					
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a cons	sequence of):					
	executed ian and irial-transi	al Exa	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
200	physicils the bu	edice		d						
Box 68760	ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	egnancy Fetal death 3	Ectopic pregn	ancy		23d. Date of deliv	
. Bo	the att	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)		Month	Day Year
P.O.	requires that the death certificate be executed the executed should be detached for use as the burial-transit	≩	Part II. Other significant conditions of	ontributing to death but not	t resulting in the u	inderlying cause	e given in Part I.		co use contribute to	
rds,	require been sig should k	eted						1 ∐ Yes 24a. Was an	24b. Were auto	obably 4 Unknown opsy findings available
3eco	he law te has l	Completed						autopsy performed	prior to co	ompletion of cause of
tal	ician: T sertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:			i. Place of Death (Chec	k only one)		panient basione
of V	g Phys er this eral dir	e: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 28a. Date of injury (Month, Day, Year	28b. Time of	nt 3 □ DOA 28c. Ir	4 ☐ Nursing H njury at vork?	ome 5 Residence 28d. Describe how in	e 6 🗹 Other (Spection) Office of the first	patient hospine
ion	tendin death. tor: Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	on		M 1	☐ Yes 2 ☐ No	OOS I amelian Observa	and Number or Rura	A Pauta Number
Division of Vital Records,	al or A		4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	eet, lactory, only	ce	City or Town, St		a noute ivanibei,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2 Medical Exam	vsician: To the best of my kr niner: On the basis of examin rse Practioner: To the best of	ation and/or inves	tigation, in my o	pinion, death occurred a	at the time, date and pl	ace, and due to the c	ause(s) and manner stated.
	To the vithir comp	2	29b. Signature and title of certifier Walkayapamam			29c, Lice	onse number 0059 46 5		Date signed (Month,	Day, Year)
U					Item 23a) (Type, F			non MA		
	V Sta	te	30. Name and address of person who N.S., P.M. A.P. K.S., N. 31. Date filed (Month, Day, Year)	32. Registra Si	gna gerke	5 200	24(1)	1011/110	-12-1	
	Registr	ar	DEC 27 2010	Lengung 10.	7					

10-09813 Joseph Price Akers

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1- For State Registrar	Certificate c	or Death	Reg. N				
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month Date December 20	Year 0835 hrs				
	ı	4a. Facility Name (if not institution, give street ar 2108 Dundalk Avenue #6	nd number)	4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore County			
Funeral		5, Social Security Number 6, Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	MM/DD/YYYYY) 9. Birthplace (State or Foreign			
Director		3/8-64-4//4 1 1 M 2 Usual Residence of Decedent	F 54 Y		8-5-1	1956 Country) N()			
w any	İ	10a. State 10b. County	10c. City, Town or Loca	ation		10d. Inside City Limits			
h the Maryland 3a or 28a-f sho lotified at once.	Director	10e. Street and Number	eE DUN	10f. Zip Code	10g.	Citizen of What Country?			
h the M. 33a or 2		2108 Dundalk Ave	enue #6	21222		USA			
eath wit	Funeral		ed Forces? If	/as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.			
s afte	ᇍ	3 Widowed 4 Divorced If Yes, Giv or Dates:	e Year AFK 1955 1	Yes 2 No specify:	work done 16	b. Kind of Business/Industry			
72 hours n "natu		15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) Colle		most of working life. DO NOT use reti		D. Kind of Business/Industry			
21215-0036 mid be filed within 7. Mental Hygiene. marked other than e event, the Medical	Completed	17. Father's Name (First, Middle, Last)		RIJCK Driver	(First, Middle, Maid	Mhmore Co Schools			
ID 21215-00% should be filed with and Mental Hygiene 77 is marked other the natic event, the Mes	Be	Joseph P AKEC	5. Sp.	alic	e Kirky	/			
MD 21 od 2 should ulth and Me on 27 is ma numntic co	우[19a. Informant's Name/Relationship (Type, Print	19b. Mailin	ng Address (Street and Number or I	Rural Route Number	(City or Town, State, Zip Code)			
imore, MD 2 Pages 1 and 2 shoument of Health and Pant: Mitem 27 is reported to the content of th	Ì	20a. Method of Disposition 1 Burial 2 Cremation 3 Remov	crematory or c	osition (Name of cemetery, other place)		Dc. Location - City or Town, State			
Baltimore, permit. Pages 1 at Department of He Important: If ite Important: If ite		4 Donation 5 Other Specify:	Atlantic	Crematiel 12	123/10 0	FILENDIUGNIE, MIX			
Bal permi Depar Impo	4	21. Signature of Funeral Service Licensee	14	ome PA 2134 W	1/0/USI	SlenBurnie, MA Skon Funeral Sring Road 21232			
Physician /Medical		23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.	hat caused the death. Do not enter	the mode of dying, such as cardiac of alcohol intoxica	r respiratory arrast,	shock, heart Approximate Interval Between Onset and Death			
Examiner	274	Immediate Cause (Final disease or condition resulting in death) a. Due to (or	as a consequence of):			4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5			
	Je.		as a consequence of):						
Į.	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or	as a consequence of):						
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o, e be ysiciz	ᅙ		yes, outcome of pregnancy	-1 per me gyrr 1/		23d. Date of delivery			
8760, ifficate bo	2	23b. Was decedent pregnant in the	ive birth 2 F	Fetal death 3 Ectopic pregna		Month Day Year			
Box 687 he death certific	Physicia	1 Nos 2 No 0 Unknown	Proposed at time of death	Other (Specify)					
D. B.	ᇎ	Part II. Other significant conditions contribut		underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?			
ires that signed	ğ Ş	chronic obs	tructive pulmona	ary disease		2 No 3 Probably 4 Unknown			
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Vital ysician his cert directo	<u>~</u>	examiner? Hospital:	Inpatient 2 ER/Outpatier			sidence 6 🗸 Other; Scene			
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ision Attendii r death. ector: /	ig	Natural 5 Pending 1 d	1 12/20/10 fd 8:		unk	Number of Number City			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying Physician: To th	e best of my knowledge, death occ asis of examination and/or investig	surred at the time, date and place, and pation, in my opinion, death occurred a	I due to the cause(s at the time, date and) and manner as stated. I place, and due to the cause(s)			
To I	Medical		ner stated.	29c. License number		9d. Date signed (Month, Day, Year)			
		Calmit &	(.M)	O.C.M.E.	[December 21, 2010			
H1	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
Sta		- mi m (4.4.0)	2. Registrar's Signature	6					
Regist	СЦ	DEC 27 2010 Line							

1 - For Amend Items 25 State of Maryland Department of Health and Mental Hygiene 1 - Registrar Per Verb., 8910, Department of Health and Mental Hygiene 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Year Anarous М Medical Examiner (it not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Haltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreig 8. Date **Funeral** Months Hours Min Director Werto Kiel permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10b. County Town or Location 10d. Inside City Limits Director More 1 Yes 2 □ No 10e. Street and Nursek 10f. Zip Code 10g. Citizen of What Country? Funeral ISA 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. ģ Maryland 21215-0036 1 Yes 2 □ No 3 Widowed 4 Divorced Completed NICAH ther uprto 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) ည 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numberfor Rural Route Number avolu choda Trenue ter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c . Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Opecify) 21. Signatur f Funeral S rvice Licenses Name and Address of Facility runera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Esquer trailly list our difficus, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and I for use as the burlal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Syndrome DOWN Due to (or as a consequence of) Physician/Medical ena M< Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown Month Day Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ism, anemia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed pneumonia. Were autopsy findings available prior to completion of cause of death? Seizure disorder 24a. Was an has autonsv perform, Director: After this certificated in by the funeral director, pag morbid obesit Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide hours after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 0062735 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 5601 Loch Raven Blvd parna onna WD Registrar's Signature State park 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. rend item 27,28a-f per me g918 8-30-11 vt
State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year 1348PM Physician - WEN DOLYN 2010 BROWN 24 DECEMBER /Medical 4c. County of Death BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
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M 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Maryland **Funeral** 1 □ M 2 🗓 F -36-676 Yrs. **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 Syes 2 □ No Director ern 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ğ 3 Widowed 4 Divorced ac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. th and Mental Hygiene. 7 is marked other than "ni Elementary/Secondary (0-12) College (1-4or 5+) U.S. Dept. of the Army ttice Superviset 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 40 ٩ 19a. Informant's ame/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/14/4 permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Severn, Md 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) wings Mills, Md 21. Signature A Puneral Service Licenses 22. Name and Address of Facility Russ Horne PA Ave Balto / Holbres The 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SYSTEM ORGAN 48 HRS Physician FAILURE MULTI disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 24 HRS SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed TOXIC EPIDERMAL WEEKS and burial-trar CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar in the past 12 months?
1 Yes 2 No Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown FIBRILLATION, COPONARY ARTERY DISEASE 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an HAPERTENTION autopsy certificate 2 No 1 TYes or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 □ No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred

probable allergic reaction 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 X No 2 Accident December 2010 unknown within 24 hours after death

To the Funeral Director:

completely filled in by the f to allopurinol 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hospital 301 Hospital Dr. Glen Burnie, Md Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MI RES - 000 2010 DECEMBER 24. 30. Name and address of person who completed ouse of death (Item 23a) (Type, Print) Justin Kur.
31. Date filed (Month, Day, MORE)

OFC 27 JUSTIN KLAFF, MD 4940 EASTERN AVENUE 21224 BALTIMORE, MID 32. Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASEM. FOG. E.

(Item 23a) (Type, Print) ASTERN BLUD - MD-21227.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ Sarah Boddie 201 8:50 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical Balto 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Months Days Hours Min 5 1 2 7 2 1 1 5 Director 215-28-5888 95 N.C. Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director 1 X Yes 2 □ No MD Baltimore na 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral 1108 N. Lakewood Avenue 21213 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important, I I I fem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. and Mental Hygiene.
I is marked other than "natural", or iter
raumatic event, the Medical Examiner. Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify:Black 1 Yes 2 No Specify: If Yes, Give Year or Dates XXWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 6th grade College (1-4 or 5+) Cook Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wiley Lewis Charity Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Frazier-daughter 3915 Cedardale Road Balto, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State MD NAT MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 12-17-10 Laurel, MD Signature of Fureral Service Licensee March East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ RESPIRATORY disease or condition resulting in death) DAY Medical Due to (or as a consequence of): Examiner PNEUMONI Sequentially list conditions, Examine if a y, heading to immodely cause. Enter Underlying use as the burial-transi that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P,O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Yea Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 \square No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔼 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The desired projection is the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 di Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 die Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-500

Registrar

State

M.D

32. Registrar's Signature

EASTERN AVENUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOUEI

31. Date filed (Month, Day, Year)
DEC 2 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar		Cen	tificate of D	eath		Reg. No.		
	Physicia	n/	Decedent's Name (First, Middle, La	•				2. Date of De Month	ath Day	Year	3. Time of Death
	Medic		Deborah	Evelyn	Butler			12	22	2010	10:14A ^M
	Examin	er	4a. Facility Name (if not institution, giv			4b. City, Town, or	Location of Death		4c. County		
2.06	Forest		Family Servic 5. Social Security Number 6.5	e Foundation Sex 7. Age (In yrs. I	ast hirthday)	Belts	ville If Under 24 Hrs.	8. Date of Birl			eorges lace (State or Foreign
	Funeral Director			I M 2 VE	46 Yrs.	Months Days	Hours Min.	(Month, Da)/1964	Count	
	at at	ō	10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10	Od. Inside City Limits
	naryla 8a-f tified	Director	MD Prince	Georges	Beltsv	ille					1 ☐ Yes 2 💢 No
	or 2		10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	with s 23a ust b	Funeral	11221 Dorset La	ne		20705	5	_	US	SA	
	death item		11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?		/as Decedent of His Yes, specify Cubar	spanic Origin? (Sp.	ecify Yes or No-		e - America	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates.		☐ Yes 2 X No		, , , , , , ,	Specify:		
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an	be fil ental 'ked ic ev	မ	Joseph P.	Butler			Adele	L.	Hughes		
ary	und M s mai		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a					ode)
Σ	d 2 sl alth a n 27 i er tra		Mrs. Adele L. Le	esnitzer/Mother	r 16	River Di	rive S	Severna	Park, MI	21	146
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altimore,	Page ment ant: I ury o		4 Donation 5 Other (Spec			tion Cem.		28/2010	Clint	ton,	MD
Balt	permit. Depart Import any inj once,	13	21. Signature of Funeral Service Lieur	see		Name and Addres					Burnie, MD
			23a. Part 1. Enter the disease, or con							. vice	Approximate
	าเงูรเต่ลกก	5 VS	shock, or heart failure. List only Immediate Cause (Final			all	Charles	Tan 7.			Interval Between Onset and Death
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8760	cate I	Medical		d							
89 ×	h certifica tending p r use as t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	al death 3 🗌		y			te of delive	
Box	the deat y the at iched fo	Physician	1 Yes 21 No 9 Unknown	4 ☐ Pregnant at time of g ☐ Unknown	death 5 🗆	Other (specify)			Mo	ntn	Day Year
P.O.	that the ned be deta	by P	Part II. Other significant conditions	contributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contr	ibute to the	e cause of death?
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<u>></u>	Phys r this ral dii	<u>ان</u>	27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatient 28b. Time of	28c. Injury	4 U Nursing H		dence 6 🔀 Othe		Chier Bush
E .	nding th. Afte fune	cate	1/⊠ Natural 5 ☐ Pending 2 ☐ Accident _ Investigation	(Month, Day, Year)	injury	work?	? [™] Yes 2 □ No	200. 200011201	ion injury occurre	, ,	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled if by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	be 280 Place of trium. At he	ome, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number	er or Rural	Route Number,
Ω	spital		29a. Certifier 1 Lertifying Ph	vsician: To the best of my know	ledge, death o	ccured at the time,	date and place, ar	nd due to the ca	ause(s) and manne	er as stated	d.
	n 24 h	Medical	(Check 2 Medical Exan	niner: On the basis of examinations of the best of m	n and/or investi	gation, in my opinior	n, death occurred a	it the time, date a	and place, and due	e to the cau	se(s) and manner stated.
	Vithi Vithi Com		29b. Signature and title of certifier	1. 0		29c. License	number		29d. Date signed	(Month, E	ay, Year)
			Meelen	Blank		726	287		12/21	10	
			30. Name and address of person who	completed cause of death (Item	123a) (Type, Pi	rint)	id C	illes 6	Park No.	z (~	0780
	Stat Registra		31 Date filed (Manth, Day Year) DEC 2 7 2010	32. Registrar's Signa				0			
			/04								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26. 2010 December 9:13 Αм Josephine Dolores Cardlin Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth **Funeral** Hours 1 □ M 2**X** F 04/07/1919 New York Director 91 065-18-2129 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Ħ Director r 28a-f sl notified Harford Maryland Bel Air 1 Ves 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be. Funeral U.S.A. 600 Squire Lane "1-C" 21014 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: White Completed 3

Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be and 2 should be filed veerith and Mental Hyg 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amelia Santini Louis V. Mastromauro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15812 Brice Hollow Road, Cumberland, Md. 21502 Renee Kniseley (Granddaughter) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 Burial 2X Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory, Inc. 12/27/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disea or condition resulting in death) intracerebral Physician hemorrhage Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last 78センス7*3*899 *CardUn, JoSephir* Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death?
1 Yes 2 No performed? the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate h mpleted filled in by the funeral director, page 2 4 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [within 2 To the only one 29b. Signature and title of certifier 29c, License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m chesapeake Drive Bel Air, mo

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mont)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 20, 2010 William Lee 10:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford 812 Windstream Way, Unit A Edgewood 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Country)
Maryland 1 XM 2 - F 08/15/1938 **Director** 219-32-2934 72 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Maryland notified at 10d. Inside City Limits Director Maryland Harford Edgewood 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or other traumatic event, the Medical Examiner must be 23a Funeral 812 Windstream Way, Unit A 21040 U.S.A. or items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No 1957 Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: 1977 "natural" Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Soldier U.S. Army Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lee Matthew Cole Geneva Kathryn Funk should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trai Nancy Catherine Cole (Wife) 812 Windstream Way, Unit A, Edgewood, Md. 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Holly Hill Mem. Gard, 12/23/2010 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 old Fastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Imprediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicaf Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) Month Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a, Was an 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 \square Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident iniurv 5 Pending or Funeral Director: A sleted filled i by the fu Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

within 2 To the I

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State Registrar

only one 29b. Signature a

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

ne and address of person who completed cause of death (Item 23a) (Type, Print) 8

29d. Date signed (Month.

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Physician/ Donald Month 2 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harbor - timore Baltimore City 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Yes
July 9, 1 If Under 9. Birthplace (State or Foreign **Funeral** 1 🌠 M 2 🗆 F Months Days Hours Min Pennsylvania Yrs Director 220-30-0296 77 Usual Residence of Decedent then "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore County Baltimore Highlands 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2735 Yarnall Rd. United States 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chemical Company Mechanic other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) should be file and Mental H ပ္ Roy Vincent Crotslev Elizabeth Marie Finley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Page 1 and 2 Steven Crotsley / Son 2 Country Lane W. Newark, DE 19702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Glen Haven Mem. Park 12/21/2010 Glen Burnie, Maryland 21. Sign re of Funeral Se 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. SE; Glen Burnie, MD 0 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions Examiner if any, leading to immediate cause. Litter onderlying Cause (Disease or linjury Due to (or as a consequence of) Heus the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျှ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of Director: After to d in by the funers 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Sulcide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ertifier 29b. Signature and title 000649

State Registrar

0 V

3001 South Hanaver St.

Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Scherago

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:49AM COX-Venia 2010 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner altimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In yrs, last birthday) **Funeral** 1□ M 2DF Days Hours **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evantment in the molified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code sarden USA 2121 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Neyer Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify Ď Specify: Black 3 Widowed 4 □ Divorced Year or Dates Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker HYRS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be rogains ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90991ns sle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee Iton 23a. Part 1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock. The heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) **Physician** reas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burlal-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy signed by the a d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 DNo 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 1 Yes 2 No Other: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tule of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

272010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day RURBET CHILCOTE 06:48AM DEC 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COLUMBIA COUNTY GENERAL INSPITAL Howares 5. Social Security Number 6. Sex 1 M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 10/28/1930 181-24-4681 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland must be notified at Director 10d. Inside City Limits 28a-f MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2829 Foxhound Road 21042 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, other traumatic event, the Medical Examiner rmed Forces?

☑ Yes 2 □ No 1953-Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced 1955 Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Research Railroad To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o Warren Dewey Chilcote Caroline Freeman Robbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau David J. Chilcote - Son 32 Cypress Trail Fairfield, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent <u>Crematory</u> 12/31/2010 Hanover, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. <u>4112 Old Columbia Pike Ellicott City, MD 21043</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VENTRICULAR disease or condition resulting in death) BRULLATUM HRC Medical Examiner Courses ALTORY WYGARE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on: Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by HYP GILTON SUN Division of Vital Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown DIABETER MEULTUS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 2 🗷 Wo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗓 No Other: 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 🔼 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ulla D 36974 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VΟ 21044 DAVID MY AN JUM S 10710 CHARTER DR & 310 (COLUMBIA MO)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

272010

State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ĭ6, December 2010 02:15 P M James Robert Davis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1505 Strider Court Hanover Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 18,1937 9. Birthplace (State or Foreign Country) Florida **Funeral** Months Days Min. Hours 1 💢 M 2 🗆 F 73 Yrs Director 263-60-4551 Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the filed style and the file 23a or 28a-f sho and the fraumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be 1505 Strider Court 21076 United States Was Decedent of Hispanic Drigin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 2 No 1955-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed Specify: White 1985 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Criminal Investigator Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Joseph Davis Nell Overstreet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elvira Davis/Wife 1505 Strider Court, Hanover, Maryland 21076 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once. Date February 9 2011 Arlington National Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <u>Arlington, Virginia</u> 21. Signature of Funeral Service Licens 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Well Eston M00672 1411 Annapolis Road, Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Metastatic Head and Neck Cancer Years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Linter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year been signed by the should be detached a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Methicillin Resistant Staphylococcal Infection 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 X No rector: After this certificate the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 ី No Other: 1 🔲 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital of 24 hours a Funeral D Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lu D0045281 December 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eva Szabo, M.D., 6130 Executive Boulevard, #2132, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** DIXON 2:19 PM M WILLIE Dee 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M x2 F Director 214-58-8354 Oct 1, 1951 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is mortant. 10d. Inside City Limits 10b. County 10c. City. Town or Location ¥□Yes 2□No **Funeral Director Baltimore Baltimore City** Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 914 Cooks Lane 12. Was Decedent Ever in U.S. Armed Forces?

Umyes 2 mo Myes, Give 1970
Year or Dates: 1070 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2√☐ Married 1 □Yes 2√□No 1970 Specify Specify: Completed by Black 3 Widowed 4 Divorced 1970 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lola Mae Dunston Vernell Dunston မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Cooks Lane Baltimore, Maryland 21229 Larry Barnes 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Mulial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/03/11 Owings Mills, Md. Garrison Forest Veterans Cemetery 21. Signature of Puneral Service Licepses 22. Name and Address of Facility Estep Brothers Funeral Service, P. 23a. Part I. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE nours **Physician** METABOLIE 3 ACIDOSIS /Medical Due to (or as a consequence of) Examiner 3 hours CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed DISEASE months CORONARY ARTERY Box 68760, Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy After this certificate has been signed by the atternormal director, page 2 should be detached for it Month Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ MYELOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed Were autopsy findings available prior to completion of cause of autopsy performed death? 2 No 1 ☐ Yes 2 **X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation after death.

Director: Aid in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0053928 12/20/2010 BEEUM, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURATYA BELVEDERE AVENUE 2434 , BALTIMORE W 31. Date filed (Month, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 21 Physician/ 1:10A. M William J. Dmuchowski 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson <u>Gilchrist Hospice Care</u> Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, OCL. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1**X** M 2 □ F **Director** 131-26-9543 77 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits with the Maryland Director or 28a-f 1 Yes 2 ☐ No Baltimore Marylanþ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "— any injury or other traums**. 21214 U.S.A. 3204 Batavia Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2X No Specify: Specify: White Completed 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pool Operator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Dmuchowski Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3204 Batavia Avenue, Baltimore, Maryland 21214 Guy Dmuchowski/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, Inc. 12-22-10 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel 6009Harford Road, Baltimore, Maryland21214 mickeel margull 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death DOUMMA Physician/ disease or condition resulting in death) Medical (o as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on use as the bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 📈 Other (Specify) 🗤 SPL 🗢 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account of the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

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Tonison (m)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2010 5:30 A M DUNIE LESLYE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE 402 UPLAND ROAD If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 07/10/192 1 □ M 2 🗓 F MD Director 219-18-9944 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 402 UPLAND ROAD 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 Tes 2 TNo Specify: If Yes, Give 3 🛛 Widowed 4 🗆 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+)
5+ Elementary/Seconday (0-12) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ GUSTAV LEIBOWITZ MOLLYE KAUFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD GAMERMAN/SON UPLAND ROAD, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM 12/24/2010 REISTERSTOWN, MD Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. une 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ CARDIAC ARREST disease or condition resulting in death) 1 DAY Medical Due to (or as a consequence of Examiner ARTERIOSCLEROSIS 10 YEARS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4 Pregnant 5 Other (specify) detached 9 Unknown rate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate I 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Iniury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) 24 hours edical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERREN M. HIMELFARB, MD, 1900 E. NORTHERN PKWY., BALTIMORE, MD 21239 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 2 Registrar

10-09851 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Larry Clifford Davis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 21, 2010 Clifford 1750 hrs **Medical Examiner** LARRY 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 1109 Anglesea Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Hours Country) W - VI CAINIA Director 217-48-6466 1 M 2 F 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 23a or 28a-f show notified at once. MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10g, Citizen of What Country U-5-A 109 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed ፩ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) JOHN Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Truckin RIVER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 lero 10 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12-23-2010 4 Donation 5 Other Specify 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** Between Onset and failure. List only one cause on each line Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and led for use as the burial - transit Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Year detached for use as past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed by ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? Yes 2 No 2 No director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Pending the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier December 22, 2010 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 31. Date filed (Month, Day, State racker

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical December 22, 2010 10:15A M EMMA JANE HULL EDER 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County STELLA MARIS HOSPICE Timonium 8. Date of Birth Apr 1, 1920 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 1 □ M 2 X F Ohio 123-03-5487 **Director** 90 Apr Usual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland|Baltimore County Timonium 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21093 USA 2300 Dulaney Valley Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. ō, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Statistical Clerk Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o Floyd Hul1 Grace Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane E. Whitten (Daughter) 12896 Eagles View Road, Phoenix, MD 21131 permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. Most Holy Redeemer Cem 12/27/2010 Baltimore, Maryland 21. Signatur / Funeral 8 min Lockse Mitcheck Wiedereld Funeral HOME, 6500 York Road, Baltimore, Maryl INC Lawson Martin D. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Onset and th Immediate Cause (Final Ph sician/ 0 disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): 0/156476 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Month Day Year cate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? hours after death. Ineral Director: After this certificate 1 ☐ Yes 2 ☒ No __ Yes Division of Vital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) To the Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie ZUI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093 32. Registrar's Signature State Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cod PM 09:30 Medical 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Mosbilal Baltimare Of If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F 9 Yrs. Months Hours Min (Month, Day, Ye *345-86-5*35 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits **Funeral Director** 1 ☑ Yes 2 ☐ No MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces:

1 Yes 2 If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be ည 19b. Mailing Address (Street and Number or Rural Route Numb State, Zip Code) MD 21133 Baltimore, 20b. Place of Disposition (Name of gemetery, crematory or other place) 20a. Method of Disposition Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HMORE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vausho Signature of Funeral Service Lice 115town, MD & 1133 23a. Part 1. Enter the disease, or comp., ations that caused the death. Do not enter the mode of dying, shock, or had failure. List only of e cause on each line. Onset and Death Immediate Cause (Final Sersis Physician/ disease or condition resulting in death) Medical Due to (or as a con equence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or limiur) that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cellutitu 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 DAYO မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 MBBS RES-000 ,22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Sinai unit KOPOGX , MBBS Mospital

State Registrar

Collein

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Joseph . T. Elsmore 1.20 P December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7300 Gunpowder Road Baltimore <u>Middle River</u> 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Months Days Hours Min Month, Day, Year, June 16, 1 1934 New Jersey 1 XM 2 - F Director 144-26-5593 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7300 Gunpowder Road U.S.A. 21220 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 V Yes 2 No
If Yes, Give 1 Never Married 2 Married ξ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Transit Driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Cain Charles Elsmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7300Gunpowder Road, Baltimore, Maryland 21220 Muriel Elsmore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State HolyCrossMausoleum 12-17-10 N.ArlingtonNewJersey 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P. A. mulicul P. Mau 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final End-Stade CVA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Matural work? 1 ☐ Yes 2 ☐ No 5 Pending thin 24 hours after death.

the Funeral Director: Af
impleted filled in by the fu death. Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) ns Rajup alnemo DO 057465 12/15/10 1.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rayga (KH, MID 2835 SMITH AV-Baltimore, MD 21209-5-203, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

10-09845 Robert Erlich Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physici	an/							- 1	2. Date of Deal	ath Day Year	. 1	Time of Death
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		7111 Park Heights Avenue Apt.403 Baltimore					N/A					
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Baltimo permit. Page Department o Important: injury or ott		21. Signature of Funeral Serv	celicensee		22. Na	lame and Addre	ess of Fac	cility SOI	L LEVIN	NSON & BR	OS.,	INC.
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/Medical		failure. List only one cau Immediate Cause (Final disea	use on each line.								Be	etween Onset and Death
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44		25 Was case referred to medi	lical			26 Plr	oce of Dea	ath (Check on	1 ✓ Yes		✓ Yes	2 No
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Attendary death	Certification:	2 Accident	ending nvestigation 28e. Place	e of Injury - At h	nome, farm, street		Yes 2		28f. Location (f	Street and Number	or Rural Ro	oute Number, City
Divi	ertif		ould not be etermined (Specify)						or Town, S			
Division To the Hospital or Attent within 24 hours after death To the Fuceral Director:	Medical C	29a. Certifier (Check only 1 Certifying	Physician: To the best Examiner:On the basis o	of examination a								use(s)
To To COUT	Med	29b. Signature and title of cert	and manner state	ated.		29c. Lice	nse numb	er		29d. Date signed	(Month, D	ay, Year)
		0_m)				0.0	C.M.E.			December 2	.2, 2010	
81		30. Name and address of personna M. Vincenti,				Penn Stree	et Baltir	more ME	21201			
1	tate	31. Date filed (Month, Day, Yea	ar) 32. Reg	gistrar's Signat	NICO A		71, Daiti	IIOIE, IVID	21201			
Regist			/ 2010 V2.		back	\[\]						

DHMH 17 Rev 1/2001

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ORIGINAL

10-09795	
Delroy Foster	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H Months Days Hours M	Irs. 8. Date of Birt	h(MM/DD/YYYY) 9. Birt Foreig Cou	
J.	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
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after de		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify:	odustru –
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be Con	Lerm 105ter /tele		ambe	
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Baltimore, permit. Pages 1 an Department of Hea Important. If ite		A Donation 5 Other Specify: The Signature of Funeral Service Licenses: 22. Name and Address of Facility	3405 W	1000	un ST.
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ion (trendin leath. tor: A the fu	atior	Natural 5 Pending 2 Accident Investigation	67.		D to Number City
i P a a i i i i	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (or Town, S	Street and Number or Ri State)	ural Route Number, City
D To the Hospital within 24 hours To the Funcral	Medical C	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, death occurred at the time, date and place, only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	and due to the cau ed at the time, date	se(s) and manner as sta and place, and due to t	ted ne cause(s)
To Tro	Med	29b. Singulature and little of certifier 29c. License number		29d. Date signed (Mo	
		Ciclo Valler Jeck 408 O.C.M.E.		December 20, 2	U10
		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, M	MD 21201		
S Regis	tate	22 Chaintearte Signatura			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and rtificate of Death		2010	40566
		-	Registrar 1. Decedent's Name (First, Middle, Last)	Timodio or Dodan	Reg. N	NO.	3. Time of Death
	Physicia		Edward Houlk Fish Sr.		December 2	20. 2010	9:55 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dear		4c. County of Death	1 7 . 33 . 1
	LAGIIIII	CI	Gilchrist Hospice	Towson		Baltimore	e
	Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs		9. Birth	place (State or Foreign
	Director		217-16-5933 1 M 2 □ F 87 Yrs.	Months Days Hours Min	11/8/23	" Mar	yland
Τ.	ow t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Literature	ncation			10d. Inside City Limits
	rylan I-f sh ied a	5				1	1 🗆 Yes 2 🔼 No
:	r 28a notif	Pire	MD Howard Ellico	tt City 10f. Zip Code	100.6	Citizen of What Cou	
:	ith th	Funeral Director		21042	Tog. v	USA	nuy:
:	ath w	nue		Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Americ	can Indian
ο.	or ite	by F	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Never Married 2 ☐ Married If Yes, Give	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White,	
ي ا	rsatt iral", Exar	ed k	3 ⚠ Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 Yes 2 No Specify:		Specify: Wh	ite
9500-61212	hou "natu dical	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of wo	16b.	. Kind of Business In	dustry
<u>,</u>	nin 7.3 ne. than e Me	шо	Elementary/Seconday (0-12) College (1-4 or 5+) life. I	OO NOT use retired)		Automoti	***
V	d with	Be C	12 17. Father's Name (First, Middle, Last)	Mechanic	(First Middle Molde		ve
Maryland	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To E	Samuel Houlk Fish		_{ume (First, Middle, Maide} Ann Hare	en surname)	
<u> </u>	ge 1 and 2 should be it of Health and Men I fitem 27 is marke or other traumatic			ing Address (Street and Number or R		or Town State Zin	Code)
Σ	12 sh Lithar 27 is rtrau	53		East Summit Dr. L			
ē, j	1 and f Hea item othe		20a. Method of Disposition 20b. Place of Disp	osition (Name of		. Location - City or To	
Ê,	Page lent o nt: If ry or			ematory or other place) e Crematory 12	/24/10 Ba	ltimore,	Maryland
baitimore,	permit. Page 1 and 2 si Department of Health a Important: If Item 27 is any Injury or other tra once.	- 6		22. Name and Address of Facility L	oudon Park	Funeral H	ome
מ	B B E B	90	Eugen Cat 1/1 3	3620 Wilkens Ave.	Baltimore,	Maryland	21229
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
P	hysician/	V. II	Immediate Cause (Final disease or condition	cardionyo	pathy		Onset and eath
1	Medical Examiner		resulting in death) Due to (or as a consequence of):	9			
		er	Esquentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
7	ed 1sit	min	cause. Enter Underlying Cause (Disease or linjury				
t !	xecur n and al-tra	Еха	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
2	s be e sicial buri	dical Examiner	d				
2/0	incare ig phy as th	Med	IF FEMALE:				
20 X	r use	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐ Ectopic pregnancy		23d. Date of deliv	
POX	the at	Physician/Me	1	Other (specify)		Month	Day Year
5	at the d by t letach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e, Did tobacco	to use contribute to t	he cause of death?
S,	signe	d by	Devention		1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
	requi shoul	lete			24a. Was an	24b. Were auto	ppsy findings available
Records,	e has	Completed			autopsy performed	? death?	ompletion of cause of
	iffication, pe	0	25. Was case referred to medical	26. Place of Death (Ch	1 ☐ Yes 2 🚾 eck only one)	No 1 Yes	2 LJ NO
VITA	ystcii is cer direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing	Home 5 Residence	6 Other (Specif	nospice
5	ig Fin ter th neral		27. Manner of Death 28a. Date of injury 28b. Time of Month, Day, Year) injury injury	of 28c. Injury at work?	28d. Describe how inj	jury occurred	-/
0	eath. eath. or: Af the fu	tica	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No			
DIVISION	or And	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta		I Route Number,
ָ ב	To the chostnal of Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (
	thin 24 the F mplete	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge	death occurred at the time, date and p	lace, and due to the caus	se(s) and manner as s Date signed (Month,	tated.
	≥ ≥ 5 8		A Paga A Da and				
	14		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			v 21 2010
Ì	100		AARON (CHAMIES NO	5701 N. Ch	ince ST	Tansu	NM
	Stat Registra		31. Date filed (Month, Day Year) 32. Registrates Signature 1				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mark Joseph Gugerty Jr. 8:00 Ам 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 8. Date of Birth Month, Day, Year, December 24,1924 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Days Hours Caughty)
Maryland 85 Director 219-12-7141 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland I and Mental Hygiene.
I see marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland **Baltimore** Lutherville 1 🗆 Yes 2 🗓 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 607 College Ave. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗌 Widowed 4 🗆 Divorced Specify: white Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) installer telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Arthur Mark Joseph Gugerty other traumatic and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Alice Gugerty/wife Lutherville, MD 607 College Ave. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Dulaney Valley Mem GardDec. 28,2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore. 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LANDROSCHIC disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter ordenying Cause (Disease or linjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending the included. the attending physician and ned for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🗌 No been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of on slac 24a. Was an this certificate has brain that the standard control of the standard control o autopsy performed? Yes 2 X No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 😿 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) (USD) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, Year) 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 0007063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles St Bultmore, MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

			Type or Print in B			•			1.0553
	•	For State Amend Item	State of Maryland s 4a,cbper dr.	Departme 910,127 Certifica	27 /20 Folling te of Death	nd Mental Hy	/giene — Reg. No.	010	40000
Dhyninia		1. Decedent's Name (First, Middle, Las				2. Date of D	eath		3. Time of Death
Physician Medica		Jacqueline	A. Geo.			Month 2	Day	Year	6:30 p ^M
Examine		4a. Facility Name (if not institution, give	1001	10	to work to	aff Willi	4c. Cc	ounty of Death	Howard Umbis
Funeral Director		110-18-7237	ex Age (In yrs. last	Yrs. If Und Month		Min. 8. Date of Bi	rth ay, Year) 5 192	9. Birth Cour	place (State or Foreign ntry)
yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
the Mar t or 28a- be notified	Funeral Director	MD HOWA	A Co1	umbia 10f. 2	Zip Code		10g. Citizer	n of What Cou	1 Yes 2 No
h with ns 23a nust l	nera	9048 Watch	light Court		21045			<u>USA</u>	
° L.9	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, sp	edent of Hispanic Origin ecify Cuban, Mexican, F 2 No Specify:	i? (Specify Yes or No Puerto Rican, etc.)		. Race - Americ Black, White, ecify:	
2 hour "natur edical	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Decedent's Us (Give kind of v	sual Occupation ork done during most o	f working	16b. Kind	of Business In	ndustry
2121 within 7 giene. er than t, the Me		Elementary/Seconday (0-12)	College (1-4 or 5+)	life. ONOT L		,	1-	Fash	ion
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or r traumatic event, the Medical Exam	To Be	17. Father's Name (First, Middle, Last)	rown		18 Mother's	Name (First, Middle	, Maiden Sur	name) Dd/c	on
fary should and M is ma		1 <u>9a. Info</u> rmant's Name/Relationship (7		19b. Mailing Addre	ess (Street and Number o	or Rural Route Numb	er, City or To	wn, State, Zip (
e, M and 2 s Health i		Jule Hazel 20a. Method of Disposition	Davghter	e of Disposition (N	Matchlie ame of	pate Date	200 1000	tion - City or To	ia MD 21045
Baltimore, permit. Page 1 and Department of Her Important if item any injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.	Removal from State	etery, crematory of	other place)	2-9-2010	3	Him	ove mi
Baltimo permit. Page · Department o Important: If any injury or once.	Ì		see //		and Address of Facility	high C. Gr	anc F	unerale	Services
m ggras	-1	Jan /hm (June	872	s Liberty R	and Rand		my mi	1) 21/83
Physician/		23a. Part 1. Enter the disease, or com shock, or hear failure. List only o Immediate Cause (Final	ne cause on each line.	Do not enter the mo	ode of dying, such as ca	rdiaceor respiratory a	rrest,		Approximate Interval Between Onset and Death
) Medical Examiner		disease or condition resulting in death)	a. Due to (r s a consequer	nce of):				-	n
THE COURSE OF STREET	ير ا و	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequer	ice off:					
uted d ansit	Examiner	Cause (Disease or linjury that initiated events	c.	100 017.				:5	
- E E	= I	resulting in death) Last	Due to (or as a consequer	nce of):					
760 cate be physic the br	edic	·	d						
ords, P.O. Box 68760 requires that the death certificate be been signed by the attending physici should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc		c pregnancy		230	d. Date of deliv	/ery
Boy e death the att	iysici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at time of dea 9 ☐ Unknown					Month	Day Year
P.O.	P P	Part II. Other significant conditions c	ontributing to death but not result	ing in the underlyin	g cause given in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
ds,	ted					1 🗆	Yes 2	No 3□Pro	bably 4 🗆 Unknown
Vital Records, Vital Records, visician: The law requires is certificate has been significate, page 2 should be	Completed by					24a. Was		24b. Were auto prior to co death?	opsy findings available ompletion of cause of
The un: The un: The or, page		25. Was case referred to medical			26. Place of Death	1 🗆 Yes		1 Yes	2 □ No
Vita Visicia is cert direct	To Be	examiner? 1 🗌 Yes 2 No	Hospital: 1 Inpatient 2 EF	NOutpatient 3 ☐	Othori	ing Home 5 Res	idence 6 🗆	Other (Specify	y)
ing Ph	ate:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	Bb. Time of injury	28c. Injury at work?	28d. Describe			
Division of all of a strength of a strength of all Director. After the death, all Director. After the death in by the funeral of a strength of	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		M e, farm, street, facto	1 ☐ Yes 2 ☐ N ory, office		Street and N	umber or Rura	il Route Number,
Division of Vital/Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but			building, etc. (Specify)			City or To	wn, State)		
e Hosp 24 ho e Fune bleted f	Medical	(Check 2 Medical Exam	sician: To the best of my knowled ner: On the basis of examination a se Practioner: To the best of my kn	nd/or investigation, i	n my opinion, death occu	rred at the time, date	and place, an	d due to the ca	ause(s) and manner stated.
To th within To th comp		29b. Signature and title of certifier	0 :		9c. License number	20		igned (Month,	
O CALL		20 Name and address of	rg MD	Ra) (Time Pri-+)	DOO 1011	227	10	2/1/	10
8.1	1	30. Name and address of person who	TOTO 8	Samuel	Morse Dr	- Colun	ibia.	MD	21045
State Registrar		31. Date filed (Month, Day, Year) DEC 27 201	O Registrar's Signature	park	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0:45 A)ECE17BER 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner if Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 💢 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Funeral Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced lac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lemeter 22 Name and Address of Facility
JUSEPH L. RUS
2-2-72 W. NOTT 21. Signature of Funeral Service Licensee wheral Hom Home Ave. Herris W. North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** 18001 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-trar Due to (or as a consequence of): attending physician a for use as the burial-The law requires that the death certificate be IF FEMALE: ned by the attendir detached for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown P.0. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 5 HVO After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗀 Yes 2 ER/Outpatient 3 DOA 1 hpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 🗆 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature at 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, DEC 2 Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:55AM श्र 2010 Helms Linda <u>Janice</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** WICOMICD Hospice at the lake Coastal Usbur 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 □XF (Month, Day, Yea 2/5/195 Yrs Maryland **Director** 218-68-6296 58 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland must be notified at Director 1 🗆 Yes 2 🛛 No Westover Maryland Somerset 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 28863 Revells Neck Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. other traumatic event, the Medical Examiner Black, White, etc. ō 1X Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within <u>Disabled</u> Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mollie Matilda Beam Clifton McSwane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other tra 28863 Revells Neck Road Westover, Maryland 21871 Jerry Adam Helms (Brother) NUN 20a. Method of Disposition 20b. Place of Disposition (Name of Date 12/24 20c. Location - City or Town, State cemetery, crematory or other place, 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gard. 2010 Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski DFuneral Home 1407 Old Fastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 🗌 Yes 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural Accident injury work' 5 Pending after death.

Director: Aft in by the fur 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State)

DHMH 17 Rev 7/2009

Registrar

24 hours a Funeral I

within 2 To the F

Medical

29a. Certifier (Check

only one) 29b. Signatur

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HIMMA

910

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

EASTERN SHORE DR. SALISBURY MD21804

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DECEMBER Day 20 Physician/ 2010 9:31 Kathleen Frances Harris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Months Days Hours Month, Day, Year 3/2/1959 Maryland Director 213-82-3412 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location death with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 XNo Dundalk <u>Maryland</u> Baltimore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 2202 Searles Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Payroll Clerk Restaurant Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Madeline League Frank Joseph Cicero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2202 Searles Road Dundalk, MD 21222 Burton Harris (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ∑Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani lespiratory disease or condition resulting in death) 2011/15 Medical Due to (or as a consequence of) Examiner Servis Weeks Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attention abusinan and been signed by the attending physician and should be detached for use as the burial-transit Dermatomyositis that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ⊑ g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🗓 No Other: ျှ 1 🗌 Yes 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔁 Natural 2 🔲 Accider work? injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-21-2010 0047223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Hath Charles St Karen m. Piper, MD Suite 5218 Baltimore MD 21204 31. Date filed (Month, Day, Year) egistrar's Signatur State Registrar

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Physician Medical Examine	aminer Alethea Francine Hanson												Year 3, 2010		3. Time of Death 1128 hrs	
	Facility Name (if not institution, give street and number) 1000 North Gilmore Street							4b. City, Town, or Location of Death Baltimore				4c. County of Death $N \ / \ A$				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth														
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after d	> \ \	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 y							A				Specify:	Diacin		
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y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fahr traumatic event, the Medical Examiner must be notified at once To Be Completed by Euroaral Director	Fr 19a. Int	Franklin Cycer Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or									Vashington Rural Route Number, City or Town, State, Zip Code)					
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Bal permi Depa Impo	21.30	21. Signature of Funeral Service Licensus 22. Name and Address of Facility Estep Brothers Funeral Service 1300 Eutaw Place, Baltimore, Md. 2121													d. 21217	
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W V	(20.1)	No. name and address of person who completed cause of death (Item 23a)										December 17, 2010				
le		ne and address o ron Locke MI		sistant Medica			1 Penn	Street	Baltim	ore, MD	21201					
Stat Registra	e 31. Dat	e filed (Month, Da	y Year)	10 Z2. R	Registrar	s Signature	back	1								

DHMH 17 Rev 1/2001 OCME 2006

Fortient is known as Corresse it Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Corresse H. Hill 18:24 December aou Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Boiltimore Sinai Hospital Baltimore CITY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min: (Month, Day, Year 1 M 2 P Director Maryland Aug 25, 1925 <u>220-20-3159</u> Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 27 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore **Baltimore** Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 21207 2020 Featherbed Lane - # 233 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Phoebe Graves George Graves Sr. permit. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2020 Featherbed Lane - #233 Baltimore, Maryland 21207 Department of Health Important: If item 27 any injury or other to once. Melvin A. Hill 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Owings Mills, Md. 12/29/10 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 21. Signature A Fund al Service Licen 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 2 23a. Part Forter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Intra creunical day Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence on cause. Enter Underlying burial-transi Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760 the as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant Pregnant at time of death 5 Other (specify) be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease Artery Cononary 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an Congestive Heart tailure autopsy perform has prior to completion of cause of page 2 death?
1 Yes 2 No Diabetes 2 No this certificate Yes 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☐ No မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 🗆 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After iniury 1 Natural 5 Pending 24 hours after death. Funeral Director: A Investigation Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES -000 December 19,2010 MD

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State

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OF BALTIMORY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABADIWA

KATRINA AB
31. Date filed (Month, Day, Year)

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M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec mo 4a. Facility Name (if not institution, dive street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore Seasons Hospice 8. Date of Birth (Month, Day, Yea Nov. 13, 1 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Months Days Hours Min 215-76-4992 1958 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 U.S.A. 1923 Breitwert Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. 1 Never Married 2 XMarried If Yes, Give Year or Dates 1 ☐ Yes 2√☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) NEVER WORKED VENEZ WORKED 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Hargadon, Sr Margaret Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 Breitwert Avenue, Baltimore, Maryland Patricia M. Hargadon 1923 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, ArdentCremation, Inc. 12-27-10 Hanover, Maryland 21. Signature of Funeral Service Licenses Marzullo Funeral Chapel, P. A Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

permit. Page 1 and 2 should be filed. Department of Health and Mental Plimportant: If item 27 is many injury or other. Pnysician/ Medical Examiner

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Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 been signed by page 2 should After this certificate has To the Funeral Director: After this certific completed filled in by the funeral director,

disease or condition resulting in death)	a. Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury	b. Due to (or as a consequence of):	
that initiated events resulting in death) Last	c. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	230

Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	,				
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Complet					24a. Was an autopsy performed 1 \square Yes 2	prior to death?	utopsy findings available completion of cause of
Be (25. Was case referred to medical			26. Place of Death (Che	ck only one)	10	
10	1 Yes 2 No	ospital:	ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 Residence	6 Other (Spe	CITY DI
ficate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fact	ory, office	28f. Location (Street City or Town, St		ural Route Number,
Medica	(Check 2 Medical Examine	er: On the basis of examinatio	n and/or investigation,	at the time, date and place, a in my opinion, death occurred curred at the time, date and place	at the time, date and pl	ace, and due to the	cause(s) and manner stated.
_	29b. Signature and title of certifier	n	10 n 2	9c. License number	29d.	Date signed (Mon	

State Registrar 31. Date filed (Month, Day,

within 24 hours a

who completed cause of death (Item 23a) (Type 69

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ DECCMBA 2010 Dona1d Lee Hoyle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Zurnte AMNE CHEN isperimore Whennerom mesucal Ce If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Social Security Number **Funeral** 1 🔀 M 2 🗆 F Months Days Hours July 7. 1938 Marviand 216-26-7741 72 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 1 Yes 2 X No MD Arbutus Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ms 23a or must be n Funeral USA 21227 1417 Sulpher Spring Rd. ural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify:White "natural" 3 Widowed 4 Divorced Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner ulth and Mental Hygien 27 is marked other the r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Younkins Louise Hoy1e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trauonce. 1417 Sulpher Spring Rd., Arbutus, MD 21227 Rachel L. Hoyle (Daughter) Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Baltimore Crematory 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 12/23/10 Baltimore, Maryland 4 Donation 5 Other (Specify) Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1- Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ TAC resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin burial-transi Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year signed by the atte Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Junknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe nis certificate h I director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☐ No Hospital: ည 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

B

only one) 29b. Signature

31. Date filed (Month, Day,

d title of certifier

and address of person who co

32. Registrar

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ 2010 Wylie Jones 12:35 ам Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Good Samaritan N/H If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) 3-29-1931 1 √ M 2 □ F Months Days Hours Min. Director 218-26-6814 Usual Residence of Decedent 28a-f show 10c. City, Town or Location death with the Maryland 10a. State 10b. County 10d. Inside City Limits Director must be notified MD na Baltimore 1 🗶 Yes 2 🗌 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4749 Wrenwood Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 10 þ 1 X Never Married 2 Married Yes Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) State of MD .2th grade Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental ant: If item 27 is marked ပ William Jones Eliza Gladden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elnora Wardlow-Sister Winston Avenue Balto, MD_ 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pk 12-22-2010 RANDALLSTOWN, Kina Memorial 21. Signa 22. Name and Address of Facility March East F/H re of Funeral Service Licenses 1101 Ε. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Yes 2 1 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: To 2 ENO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Aursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? s after death. 2 🗌 No Accident Investigation filled in by the 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier To the Hosp within 24 hou To the Fune completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 058570 and address of person who completed cause of death (Item 23a) (Type, Print) 560/ Cuch Ravon Blud Balt

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 7500M **Physician** har 10 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N Good Samaritan Hospital Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Year) 1 □ M 2 KF 214380503 Director Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Marical Event nust be notified an once. 1 Yes 2 No Baltimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15 2123c 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ Specify 3 Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ustodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ 0 lia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stanewar)) 3 /3⁻³⁹ Dirah 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Puner Service Licenses 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Lause (Final **Physician** elody disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 □ Yes 2. No Month Dav Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🔲 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 200 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manper of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:..
completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) License number 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DEC 27 2010

5601 Loch Raven Boulevard, Baltimore MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Charles Van Kershaw Jr. 1:42 20, 2010 December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Riverview Care Center Baltimore Essex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Feb. 2, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Min. Months Days Hours 1**1** M 2 □ F 218 18 3381 88 Alabama Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2X No Baltimore Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 27 Cardinal Rd. 21221 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Railroad Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Schmidt Charles Van Kershaw Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Van Kershaw III (Son) 8107 Edwill Avenue Baltimore, Maryland 21237 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory Inc. 12/21/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Sign ure of Funeral Service Licensee 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmona disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

use as the burial-tran

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To the Funeral Director: A completely filled in by the fu

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Certification: To

Medical

law requires that the death certificate be executed

Box 68760,

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Records,

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of

Physician:

or Attending Division

Hospital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examples quet be notified at

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Maryland

Baltimore.

should be filed within and Mental Hygiene. marked other than

i. Pages 1 and 2 should be tment of Health and Menta tant: If item 27 Is marked ijury or other traumatic en

Department o Important: If any injury or once,

Director

Funeral

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Completed

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Examiner Physician/Medical Completed by

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24a. Was an autopsy 1 ∐Yes

26. Place of Death (Check only one)

Were autopsy findings available prior to completion of cause of death? 2 NO

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner' 1 ☐ Yes 2 No 27. Manner of Death
12 Natural
2 Accident

3 ☐ Suicide

29a. Certifie

4 Homicide

(Check only one)

5 Pending investigation

6~11

6 ☐ Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: Aurising Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Suite 204 Parkville MD 21234

29b. Signature and title of certifier

M.D.

29c. License number 69540 29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ation

8813 Jigor Shah 31. Dale filed (Month, Day, Year) DEC

Now many 32. Fegistrar's Signature

words Rd

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	ite of Maryland /		tment of Healt ificate of Death			eg. No. 2	10	40579
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month Decembe		ž610	3. Time of Death 10:32 a ^M
	Medic Examin	al	Tuyet Lieu 4a. Facility Name (if not institution, give street a.	nd number)		4b. City, Town, or Location		becambe	4c. County		10:52 a
	LXummi	.	9979 Timber Knoll	Lane		Ellicott C	ity		Howa	ard	
	Funeral Director		5. Social Security Number 212-92-4627	7. Age (In yrs. last bir 91	Yrs.	If Under 1 Year If Und Months Days Hour	der 24 Hrs. rs Min.	8. Date of Birth <i>(Month, Day,</i> 08/26/1	Year) 919	9. Birthpl Counti	lace (State or Foreign ry) China
	and show at	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Loca	ation				10	Od. Inside City Limits
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	ith the 23a or st be n	Funeral Director	10e. Street and Number 9979 Timber Knoll L	ane		10f. Zip Code 21042			10g. Citizen of \	What Count ed Sta	-
	eath w tems ? er mus	Fune	11 Marital Status 12. Wa	s Decedent Ever in U.S.	13. Wa	as Decedent of Hispanic Yes, specify Cuban, Mexi	Origin? (Spec	ify Yes or No-	14. Rac	e - America	an Indian,
9030	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	If Y	ned Forces? Yes 2 XNo es, Give ir or Dates.	- 1	Yes 2 No Spec			Specify.	ck, White, e	
15-(72 hou n "nat Aedica	Completed	15. Decedent's Education (Specify only highest grade com	oleted)	(Give kii	nt's Usual Occupation nd of work done during m NOT use retired)	nost of working	9	16b. Kind of B	usiness Ind	lustry
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Baltimore, Maryland 21215-0036	d be filed Mental Hy Irked oth	To Be	17. Father's Name (First, Middle, Last) Unknown			18. Me	iother's Name Unkn		flaiden Surname	a)	
Aan	and 2 should be fill Health and Mental tem 27 is marked on ther traumatic ever		19a. Informant's Name/Relationship (Type, Prin		-	Address (Street and Nur					
ē,	and 2 Health		Quan Fung — Daughte: 20a. Method of Disposition	20b. Place of	of Disposi	Timber Knol	1	ETTTCC	20c. Location		
m 0	Page 'nent o'nent o'ant: If iant: If iant or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State cemete Crest		atory or other place) n	12/28	/2010	Marri	otts	ville, MD
Balt	permit. Departr Import. any inji	g j	21. Signat ve of fun II Se vice Licensee	401411		Name and Address of Fa					
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987	ertifical ding ph	/Me	IF FEMALE: 23c. If y	es, outcome of pregnancy					23d Da	ate of delive	an/
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	Live Birth 2 Fetal dea Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)					Day Year
s, P.O.	ires that the signed by Id be detained	by	Part II. Other significant conditions contributi	ng to death but not resulting	g in the un	derlying cause given in P	Part I.				e cause of death? pably 4 Unknown
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Ę.	Physic this ce al dire	욘	1 Tyes 2 Tho	1 Inpatient 2 ER/C	Outpatient . Time of	3 DOA Other: 4 D			ence 6 Oth)
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ivisio	l or Atter after des Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	. Place of Injury - At home, f building, etc. (Specify)	farm, stree	et, factory, office	2	8f. Location (St City or Town	treet and Numb n, State)	er or Rural	Route Number,
	Hospita 24 hours Funeral eted fillec	Medical	29a. Certifier (Check only one) 3 Certifying Physician: 1 Certifying Physician: 1 Certifying Nurse Prac	the basis of examination and/	or investig	gation, in my opinion, deat	th occurred at 1	he time, date ar	nd place, and du	ie to the cau	use(s) and manner stated.
	To the within To the compl	Σ	only one) 3 Certifying Nurse Pract 29b. Signature and title of certifier	C O lo A O	wieuge, uc	29c. License numb			29d. Date signe		
	A		Herri	4110		K1343	26		XCem	oer í	23 2010
	4		30. Name and address of person who complete	CRNP GTE	V 10	J. Chones	Stree	et Tou	akn	MD	21204
	Sta Registr		31 Date filed (Month Day Year)	32, Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2-2010 Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Birthplace (State or Foreign Country) MD Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. Hours 0770971949 255-76-5179 61 **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore Baltimore 1 ☐ Yes 2X No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 4120 Annapolis Road, Apt 2A USA. Funeral Was Decedent Argued Forces?
1.2 Yes 2 1966–1969 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Self-employed Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Laster, Sr. Ruth Laster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Eastlynne Ave., Baltimore, MD 21223 19a. Informant's Name/Relationship (Type, Print) Heather Ladd / Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 12/29/2010 Odenton, MD Arundel Crematory W. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 The M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year Pregnant at time of death 2 No ned by the a g
Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signer should be 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed?

1 Yes 2 No 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital 2 No Other: ျ 1 Yes XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending work' 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print)

HMH 17 Rev 7/2009

State

Registrar

3900

27201

10-09268 Randy Littleton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 405 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 2, 2010 Medical Examiner 1758 hrs Randy Thomas Littleton 4b. City, Town, or Location of Death 1c. County of Death 4a. Facility Name (if not institution, give street and number) Chestertown Kent Chester River Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Months Days Hours Director 49 Oct. 23, 1961 1X M 2 F 215-58-2815 Yrs Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 1 Yes 2 XNo or 28a-f show ral", or items 23a or 28a-f sho Chestertown Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
soit: If item 27 is marked other than "natural", or items 23a or 28a-f sho re other travel. The page of the Medical Examiner must be optified at occ. Marylan¢ Kent Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 100 Fairwell Road 21620 uneral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Yes 21 No 1 Yes 2 No specify: If Yes, Give Year 3 Widowed 4 Divorced Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 12 HEVERVORKED VEUER WORKED 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Janie E. Cochran LeRoy Littleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3002 Sycamore Court, Joppa, Maryland 21085 Janie E. Cochran/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 XXCremation 3 Removal from State ArdentCremation, Inc 12-13-1 Hanover, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Marzullo Funeral Chapel, P. P. 21. Signature of Funeral Service Licenses 6009Harford Road, Baltimore, Maryland21214 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and (Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of); events resulting in death) Last and Physician/Medical physician the burial -UNPENDED AMENDED Box 68760 IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 ✔ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury (Month, Day Year) Dec 2, 2010 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Bicyclist struck by vehicle Natural after death.

Director: / 5 Pending 1 Yes 2 ✔ No 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State)
Route 213 at Round Top Road, Chestertown, MD within 24 hours a

To the Fuoeral I (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 3, 2010 30. Name and address of person who completed cause of death (Item 23a) ら Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day, Year

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

OCSAF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ZUI U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LAMARTINA 1245 AM Osep 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4ARJORD Medical Center Be ChesARRAKE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 24 Hrs 7. Age (In yrs, last birthday) **Funeral** Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 1014 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Completed by 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. If Yes, Give Year or Dates 1 ☐ Yes 2 → No Specify: Baltimore, Maryland 21215-0030 Whit 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry marked other than College (1-4 or 5+) Elementary/Seconday (0-12) troduce Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) AlVATORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drughte 1702 Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of 1 X Burial 2 Cremation 3 Removal from State Vew (-36-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or con illion resulting in death)

a. Seve Sissing Constitution and the consequence of the consequence Priysician/ Medical Examiner Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No been signed by the a should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown deconditioning 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No 1 🗌 Yes Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

29b, Signature and title

30. Name and address of person who

Registrar DHMH 17 Rev 7/2009 completed cause of death (Item 23a) (Type, Print)

32. Registlar's Ci-

hom

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

D0053568

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per fh 910 12-29-10 vt. State of Maryland / Department of Health and Mental Hygiene

			State Registrar			Cer	tificate of D	Death			Reg. No. 2	Poleston	0593
	Physicia	n/	1. Decedent's Name (First, Middle, Albert Gillett							2. Date of Death December Day 7 2 gar 0 6:30 Am			
	Medic	al			•		# 01 T		- (D 1)	122 C. R.M.			D (C) (M
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	Funeral			6. Sex 7. Ag	je (In yrs. las		If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir	th		place (State or Foreign
	Director		214-30-5118	1 ☑ M 2 □ F 7	5	Yrs.	Months Days	Hours	IVIII I.	Aug." 1	7 , Year) 1935	Mar	71and
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with	s 23a ust b	Funeral	7251 BaltoAnna	ap. Blvd.			21061				United	State	S
death	item ner m		11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Oi n, Mexica	rigin? (Spe an, Puerto	cify Yes or No- Rican, etc.)		ce - Americ	
after	al", or xami	d by	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	ied 1 Yes 2 If Yes, Give Year or Dates.	No	1	☐ Yes 2 🖾 No	Specify	y:		Specif	Whi	ite
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y (n 27 i		David Myers/Son			7251	BaltoAn				n Burni	e, MD	21061
Page 1 ar	t of He		20a. Method of Disposition 1 Burial 2 □ Cremation	3 ☐ Removal from State	. ce	metery, crem	sition (Name of natory or other place	;e)	Dec 201	^{Date} 21,	20c. Location		
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			23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that cause nly one cause on each lin	d the death.	. Do not ente	r the mode of dyin	g, such a	s cardiac o	or respiratory a	rrest,		Approximate Interval Between
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death o	e atte	Physician.	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	at time of de		Ectopic pregnand Other (specify)				N	lonth	Day Year
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or Attending P	ector: by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In		ne, farm, stre	eet, factory, office				(Street and Num	ber or Rural	Route Number,
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Hospi	within 24 hours after death. To the Funeral Director: After this certificat. has been signed by the attending physician and completed filled in by the funeral director, page 2 sh, uld be detached for use as the burial-transit	Medical	(Check 2 Medical E	Physician: To the best of ixaminer: On the basis of Nurse Practioner: To the	examination	and/or invest	tigation, in my opinio	on, death	occurred a	t the time, date	and place, and o	ue to the ca	use(s) and manner stated.
To the	within To the compl	Σ	29b. Signature and title of certifier		- Pa	· Vi	29c. Licens	e number	> / 4	~			
			Neon	re Com		M	7	71.	26-	3 1 A	Dala	when	Day, Year) 17, 20W
_	OV		30. Name and address of person (who completed cause of	death (Item	23a) (TVP)	Print) 30	en	BR	ivnie	MI	, 2	0161
	Stat Registra		31. Date filed (Month, Day, Year)	32. Regist	ar's Sign att	ure L							

AMEND ITEM#20b, perFH, G910, 12/27/2010 WS Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MURRA Physician/ Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore 324 North Grantley Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Country)
So. Carolina Days Hours (Month, Day, Year) 1 M 2 F Director Feb 17, 1949 220-56-0344 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore Baltimore City** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 U.S.A 324 North Grantley Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 Amarried Yes ? 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify Black 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Schools Crossing Guard 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Wilhelmenia McKnight Nathaniel Darger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 324 North Grantley Street Baltimore, Maryland 21229 **Eugene Murray** 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Cemetery emetery Western Baltimore, Md 12/21/10 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sediate Cause (Fins) Approximate 23a. Part 1. interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on been signed by the attending physician and should be detached for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of this certificate has page 2 autopsy performe ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 **X**Ro Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After **₩**Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Signature and title of certifier 8 who completed cause of death (Item 23a) (Type, Print) 30. Name/and/address of person Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

The law requires that the death certificate be executed physician and s the burial-tran Division of Vital Records, P.O. Box 687602 attending p the à been si certificate has b After this Director:

24 hours a To the

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show idical Examiner must be notified all

permit. Page Depertment of Important: If any injury or once.

Physician

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Physician/Medical

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Completed

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filed within 72 hours after

Baltimore, Maryland 21215-0036

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 3 5 2 7 4 9 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 21204 suite 509 TOWEN OF aster Drive 7505 Kimara m. 7 Janunt

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Ϊ<u>8,</u> Francis Mierkiewicz 5:35 Α. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore 8. Date of Birth (Month, Day, March 29 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1925 Mary Land **Funeral** 6. Sex 1**x** M 2 □ F Months Days Hours Year) 216-16-1049 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Baltimore Baltimore 1 Yes 2X No 10e. Street and Number 10g, Citizen of What Country? Funeral 1141 Wedgewood Rd 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 🕱 Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WW II Specify: White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) MD Race Tracks <u>Security</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Mierkiewicz Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Bernadrikowski (Nephew) permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 321<u>4 Bicentennial Ct..</u> Ellicott Citu, MD 21042 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Crematory or other place) @ Loudon Park 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/21/10 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Liberts 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest effects, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 **X** N 1 Tes 2 🗌 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🗶 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending 1 🗌 Yes 2 🔲 No within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and tipe 29d. Date signed (Month, Day, Year) 2010 dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

JACKIĖ

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DECEMBER 18,

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TIMONIUM.

MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's signature

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JONES,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Vear DWIGHT VINCENT MOORE 10:50a 2010 DECEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD UPPER CHESAPEAKE HOSPITAL BELAIR If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Hours Min. 1 M 2 D F 212-58-6321 58 Director Yrs. MARYLAND 8-10-1952 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 X Yes 2 No HARFORD **EDGEWOOD** MD. 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral 2448 BEAVER CROSSING RD 21040 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 YNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK 3 Widowed 4X Divorced Year or Dates 2/21/2010 1050AIM 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12)
-12-College (1-4 or 5+) CLERK RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DELORES_MOORE TAMES_MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1314 DALTON RD. PARKSVILLE, MARYLAND 21234 KELLY DICKENS (DAUGHTER) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pMETRO CREMATORY 20c. Location - City or Town, State 2XXCre 1 🗌 Buria ation 3 Removal from State 12-29-2010 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) of Furniral Service License JQNATH 21. Signature HIBNER²². Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. MONROE ST. BALTIMORE. 1721-27 N. MARYLAND 21217 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ck, or heart failure. List only one cause on each line Immer ate Cause (Final dise of or condition resulting in death) Onset and Death Physician. 12 Crani n Medical Due to (or as a consequence of): Examine M800530485 Sequentially list conditions. ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of Examir physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) been signed by the a should be detached 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 ☑ No. 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an , page 2 s autopsy performed? Hospital or Attanding Physician: The After this certificate 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No မ 1 Propatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending work? 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be within 24 hours after des To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death account at the cause of the caus Medical 29a. Certifier Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 3 only one) 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesafrate Dr. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 18 2010 Physician/ O'Neal Kelvin James 3:54 A M Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore agnes Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
1-29-1956 6. Sex 1 X M 2 ☐ F Age (In vrs. last birthday Birthplace (State or Foreign Country) Funeral Hours Director 54 220-64-5243 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho important: If item 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Baltimore 1 XYes 2 ☐ No MD na 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21229 IIS A 4717 Melbourne Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc ģ 1 Never Married 2 K Married Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: Completed 3 - Widowed 4 - Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Docton Degree Teacher Schools Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Leola M. Baker Rev. James O'Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melbourne Avenue Balto, MD 21229 Pamela O'Neal-Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 12-29-10 4 Donation 5 Other (Specify) Arbutus Memorial Arbutus, MD 21. Signature of Theral Service Licensee 22. Name and Address of Facility March East F/H Balto, 21202 Avenue MD1101 Ε. North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final disease or condition Physician/ ardiovacular Medical resulting in death) Due to (or as a consequence of) Examiner rabetec sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Insufficience Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a d be detached for Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

8

State

29b. Signature and title of certifier

Tonya 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mason

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32. Registrar's Signature

Kewin

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Scaton Ave

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore MI)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Day **Physician** 242016 ecember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1 Baltimore City

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Parks | Davs | Hours | Min. | Month Days **Baltimore City** The Johns Hopkins Hospital 5. Social Security Numbe 9. Birthplace (State or Foreign Age (In yrs, last birthday) **Funeral** 1 M 2 M 242-58-354 CAROLINA Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location 1 des 2 No Director must be notified 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö 23a Funeral Pages 1 and 2 should be filed within 72 hours after death items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify If Yes, Give Year or Dates þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First Middle Last) Be and Mental is marked ၉ 19a. Informant's Name/Relationshiv (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Num , City or Town, State, Zip Code) Health a Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other s 20a. Method of Disposition Daté 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen e 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as pulpu IF FEMALE: use. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) ed by the at detached f 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No Yes 1 Yes or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) . 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Injury 5 Pending investigation 1 Natural death. 1 🗌 Yes 2 🗌 No Accident the Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by after 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael 600 North Wolfe St, Baltimore, MD, 21287 nsheimer 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 23a per dr.,g910,12/21/2010dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 1845 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Manyland Medical Baltimore Conter If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days Hours Min. 1 🗆 M 2 😾 Sept 18, Year 1916 94 Maryland Director 215-16-5840 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 2525 W. Belvedere Avenue 21215 **USA** · death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. 'natural", black Specify: 3

Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 dietary healthcare other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ pe Harry Brooks Ethel Travis permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaTanya Wilkins/ niece 1501 N. Monroe Street Baltimore, MD 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 \square Burial 2 \square Cremation 3 \square Removal from State injury or 4 ☐ Donation 5 X Other (Specify) in state Signal Sof Funeral Soficed icensee 16 Strange and Andrew On Facili Board 655 W. Baltimore Street Director any i Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septicemia Physician/ disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Soft Tissue Infection Sequentially list conditions, Examine if any, leading to himediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: sician and burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending physic for use as the b IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death ed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown s been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this completed filled in by the funeral Date of injury (Month, Day, Year) 27. Manner of Death 28a. 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury Accident Suicide within 24 hours after death To the Funeral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 12/11 225263197 2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 27

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b, per Fh G911 1/3/11 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DMonth Physician/ Day PM DWARD ETERKIN DIO Medical BAI + MORE 4a. Facility Name (if not institution, give street and numb Town, or Location of Death Examiner OSPICE Anda NWO eason s If Unc If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign last birthday) Funeral 215-52-1654 1 🗶 M 2 🗆 F Months Hours September 23 **Director** Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 23a or 28a-f sho important If item 25 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No MHIMORE HARY And 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number North Funeral (DSA 60. 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗖 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give American 3 Widowed 4 Divorced Completed Year or Dates rican 16b. Kin of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) OH #45 INC. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ETERKIN Aniel TOSE ETERKIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 101 Willage of fine Court Apr 20 Windson Mills 19a. Informant's Name/Relationship (Type, Print) - Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition December Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Memation 3 Removal from State Baltimore, MARYland 4 ☐ Dopation 5 ☐ Other (Specify) 19900 31, 2010 Name and Address of Facility Fugerai Services
14204 M. WALLACE FUGERAL SERVICES MARIJAND 31229 21. Sign e of Funeral Service Licensee ni Clases 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line.
Immediate Cause (Final Interval Between Onset and Death NON SMALL CANCE Cou UNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. it any hadding to in much cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of Exam use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year Day 5 Other (specify) Pregnant at time of death signed by the a 2 No 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) INPATIENT examiner? Other: HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural work? 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature) and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 8395 nn) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO Nus mn 2835 AKHANI TASNEEM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Registrar	State	of Marylar		artment of H tificate of D			giene Reg. No.	10	40592
Physicia	n/	1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	Day	Year	3. Time of Death
Medic Examin	al	Mary Lou 4a. Facility Name (if not institution,	Roesky			4b. City, Town, or	Location of Death	Decemb		2010 ty of Death	12:50 PM
Examili	er	Good Samaritan				Baltimo			4c. Coun	ty of Death	
Funeral			6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birt	h v Vear	9. Birthp	place (State or Foreign
Director		246-07-7657 Usual Residence of Decedent	1 L M 2 X J F	94	Yrs.	Wichting Buys	riours iviiii.	8/29/1	916	Nor	th Carolina
and show	tor	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
Maryl 28a-f otifie	irec	Maryland Balt:	imore	Ess	sex						1 🗌 Yes 2 🗓 No
th the 3a or t be n	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Coun	try?
ath wi	uner	25 Walkern Road		edent Ever in U.	Q I12 V	21221 Vas Decedent of His	epanio Origin? (Spo	ocify Voc or No	U.S.		1 10
or ite	by F	1 Never Married 2 Marrie	Armed Fo	orces?	l l	f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		ace - America ack, White, e	
urs after ural", c	ted	3 X Widowed 4 □ Divorced	If Yes, Giv Year or D	/ e	1	☐ Yes 2 XNo	Specify:		Specia	^{fy:} Whit	te
72 hoi 72 hoi 1 "nat ledice	Completed	15. Decedent (Specify only highes)	(Give I	lent's Usual Occupa kind of work done du		ng	16b. Kind of	Business Inc	lustry
vithin liene.		Elementary/Seconday (0-12)	College (1	-4 or 5+)		O NOT use retired) Processor			Aero S	bace	
filed v al Hyg d othe vent,	Be	17. Father's Name (First, Middle, La	est)		Dava		18. Mother's Name	e (First, Middle,			
yldi	욘	John W. Lower	ry		_		Rosa M	inggia			
VICTION Should hand hand hand hand tismum traum		19a. Informant's Name/Relationshi	p (Type, Print)			ig Address (Street ar					ode)
If e, INAI yially ZILIS-DUSO 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. The stand Mental Hygiene. Other traumatic event, the Medical Examiner must be notified at		Shari Segich (I 20a. Method of Disposition	<u>Daughter)</u>			alkern Ro sition (Name of		x, Mary	Land 21 20c. Location		uun Stata
permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		State C	cemetery, cren	natory or other place	12.			•	
permit. P Departme Importar any injur		21. Signature of Funeral Service Lice		[HOI		1 Mem. Ga . Name and Address		10 1	Middle	River	r. Maryland
permi Depar Impor any ir		Muchail 6	3 salk	in 5	- B	ruzdzinsk 407 old E	i Funera astern Av	l Home l Venue l	PA Essex	Marvla	and 21221
		23a. Part 1. Enter the disease, or of shock, or heart failure. List on	omplications that	caused the deat					est,	1	Approximate Interval Between
Medical		Immediate Cause (Final disease or condition resulting in death)	a	ENd	57	Lye,	Dene-	rtin			Onset and Death
Examiner		resulting in death)	Due to	(or as a conseq	uence of):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Justo	or as a conseq	uenta of).						
uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C								
be executed sician and burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):					İ	
5 9 2 9 1	edical		d							_	
The law requires that the death certificat are has been signed by the attending phage 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant		come of pregna					234 D	ate of delive	n.
leath of atter	icia	in the past 12 months? 1 Yes 2 X No	4 Preg	nant at time of		Ectopic pregnancy Other (specify)	/				Day Year
by the	Phy	9 Unknown	9 ∐ Unki								
og 2	ρ	Part II. Other significant condition	is contributing to d	leath but not res	sulting in the u	nderlying cause give	en in Part I.				e cause of death?
require been si should I	Completed										ably 4 Unknown
The law rate has I page 2 s	ᇤ							24a. Was a autop perfoi			sy findings available npletion of cause of
ician: The certificate ector, pag		25. Was case referred to medical				26. Plac	ce of Death (Check	1 Yes		1 Yes	2 No
lysicia ils cer direct	10 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatien	Other	<u> </u>		ence 6 🗆 Oti	her (Specify)	
Attending Physician: or death. ector: After this certific by the funeral director.		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	28c. Injury work?	at 2	28d. Describe h			
ttendi death tor: A	Certificate:	2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no	ation	of lainer At la			/es 2 □ No				
after Direc		4 ☐ Homicide determin		ng, etc. (Specify		et, factory, office	'	28f. Location (S City or Town		ber or Hurai i	Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	29a. Certifier 1 Acertifying F	Physician: To the b	est of my know	ledge, death o	ccured at the time, of	date and place, and	d due to the cau	ise(s) and man	ner as stated	1.
the Hin 24 the Fit	Me	only one) 3 \square Certifying N	lurse Practioner:	To the best of m	y knowledge, d	eath occurred at the	time, date and place	e, and due to the	cause(s) and n	nanner as sta	se(s) and manner stated. ted.
viti To		30. Name and address of person when the control of	_ (1	Suhan	MI	29c. License	number	·	29d. Date signe De ce-	ed (Month, D	22, 20/0
	ŀ	30. Name and address of person w	no completed cau	se of death (Item	123a) (Type, P	rint)	10.		1/4 /	R	Finne
		Jernanie C	. 12 c fa	er al	154	60/60	in Re	m 0			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Stat Registra	~ 1	31. Date filed (Month, Day, Year)	32.R	egistrar's Signa	-						
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 6:08AM Physician/ 20<u>(0</u> 11 Kusse udia Medical or Location of Death 4c. County of Death a. Facility Name (if not institution, give street and number) **Examiner** Balti more Maryland ttosp 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Security Number Days Month Day, Country) **Funeral** Min. 4.8503 1 □ M 2 💢 F Yrs. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Yes 2 No Balt move MD 10g. Citizen of What Country? 10e. Street and Number USA. Funeral 21216 1602 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Segonday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City 19a. Informant's Name/Relationship (Type, Print) Balto 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral erv Bath MD Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease or complications that ca shock, or heart failure kist only one cause on each Immediate Cause (Final Physician/) PSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner URINAry Tract Infection Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Prodnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? ate has been signed by the atte page 2 should be detached for 5 Other (specify) Prognant at time of death Unknown Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2i□ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗆 No this certificate 26. Place of Death (Check only one) To Be 25. Was case referred to medical examiner? Hospital Other: ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 🗌 Yes 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Funeral Director: After the completed filled in by the funeral Certificate: Natural 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined hours after within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce 12010 18932 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore Registrar's State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 26 State of Maryland Department of Health and Mental Hygiene per verb., g910, 12/2//2010dnb Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Betty Ann Remley Physician/ December ት₇, 20 ነዕ 12:44 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Hospital Carroll Westminster 5. Social Security Number 216-34-2481 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 1 □ M 2 1 F Months 0770771935 75 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 ☐Xyes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1224 Bachman Valley Road 21158 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 White should be filed within 72 hours aft. 1 and Mental Hygiene. 7 is marked other than "natural", Yes, Give 1 Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Medical Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Remley Trene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sandra Remley Gasper 4311 Joshua Ct., Street, MD 21154 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 12/22/2010 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall le 4 Marsha 11 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Embolism Enysician/ Pulmonars disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to lor as a conse mence of: that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mcido i osado (Li) besit 1 🗌 Yes 2 No 3 Probably 4 Unknown certifica e has t een si rector, page 2 snould I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Januaya, M) 51705 12-20-2010

State Registrar

DHMH 17 Rev 7/2009

Walmin

DR. Westminster, M) 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

349

32. Registrar's Signature

ANSURIYA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies A	re Legible.	
State of Maryland / Department of Health and Mental Hygier		5
Contificate of Double		011

		1- For State Registrar	Ce	ertificate of De	eath	R	eg. No.	2000
Physic			ast)			2. Date of Dea	th	3. Time of Death
/ledical Exam	ine		ces Thave	r		Month Decembe	r 17, 2010	1537 hrs
		 Facility Name (if not institution, 2303 Willow Vale Road 	give street and number)		ity, Town, or Location of Elston	Death	4c. County of Death Harford	n
Funeral		Social Security Number 6.	Sex 7. Age (In yrs.		Jnder 1 Year If Under 2			rthplace (State or
Director		213 · 46 · 3590 1 Usual Residence of Decedent	M 2 F 6.	3 Yrs. M	onths Days Hours	Min. 04/3	0/1947 Foreign Co	ountry) MD
/ any		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
Maryland 28a-f show	į	MD Hart	ord t	Fallstor				1 Yes 2 No
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiest and Arris marked other than "natural", or items 23a or 23a-f she mattic event, the Medical Examiner must be notified at once	Il Director		w Vale K	oad 10f.	2104°		0g. Citizen of What Cour	ntry?
r death wi or items	Funeral	promote the second	1 Yes 2 V No		edent of Hispanic Origin? pecify Cuban, Mexican, Pu		- 14. Race - Ameri White, etc.	ican Indian, Black,
hours afte 'natural'', Examiner	by	45 Basedards Education 10	ed If Yes, Give Yeer or Dates:		2 No specify:		Specify: 3	lack
2 hour "natu	ted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's Us during most of	ual Occupation (Give kind working life. DO NOT use	d of work done e retired)	16b. Kind of Business/I	Industry
5-0036 led within 72 Hygiene I other than the Medical	Completed	27 February (0-12)	4	Progr	amer		Lockheed	Martin
21215-0 uld be filed v Mental Hygi marked other	Be C	17. Father's Name (First, Middle, La	phaver (5	15ter)	1 /	lame (First, Middle, N DUISC	laiden Surname)	
ID 21 should and Me 7 is man	P	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addr	ess (Street and Number	or Rural Route Num	ber, City or Town, State.	, Zip Code)
P B E E		Carol Sho	aver Oister			ce Balt	imore MD	21207
MOFE, Pages I au tent of He unt: If ite		20a. Method of Disposition 1 Surial 2 Cremation 3		Place of Disposition (i crematory or other pla		Date	20c. Location - City or	Town, State
·등 원조의		4 Donation 5 Other Speci	fy:	rbutus	12	2-29-2010	Baltimor	= MI)
Baltii permit. I Departm Importa		23 Signature of Funeral Service Lice 24 Signature of Funeral Service Lice	ensee	22 Name a	and Address of Facility Coreene	Funeral	Service	
Physician		23a. Part I. Frier the disease, or con	nplications that caused the death	n. Do not enter the mod	Saltimore de of dying, such as cardi	ac or respiratory arre	PIRE CZI	229) Approximate Interval
/Medical		failure. Vist only one cause on Immediate Cause (Final disease	each line. a Atherosclerot					Between Onset and Death
xaminer		or condition resulting in death)	Due to (or as a consequence of					
	L	Sequentially list conditions,	٥					
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	of):				
_ =	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):				
ecuted and transi	_		1		17111711 -00	11		
760, cate be ex physician the burial	/Medica	X UNPENDED	AMENDED item 23a	1,2/ per Mi	: 1/18/11 G9	11 66		
	J/M	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg				23d. Date of delivery	
Box 68 e death certil the attending ed for use as	cia	past 12 months?	1 Live birth 4 Pregnant at time of de	2 Fetal dea		gnancy	Month Da	ay Year
Vital Records, P.O. Box 68 hysician: The law requires that the death certifulity certificate has been signed by the attending I director, page 2 should be detached for use as	Physician	1 Yes 2 V No 9 Unknow	9 Unknown					
P.O. es that the igned by	by P	Part II. Other significant conditions	contributing to death but not re	esulting in the underly	ing cause given in Part I.		pacco use contribute to the	
uires I				_		1 Yes	2 No 3 Proba	ably 4 🗹 Unknown
Division of Vital Records, ral or Attending Physician: The law requirers after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed					24a. Was ar autops		opsy findings available ompletion of cause of
Rec The la	Ę			•		perform	ned? death?	
tan:	Be	25. Was case referred to medical examiner?			26 Place of Death (Che			, 2 110
hysic al dire	2	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nu	rsing Home 5 R	tesidence 6 🗸 Other:	Scene
n of Jing Pl After funera		27. Manner of Death 1 X Natural 5 Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	ow injury occurred	
SiOl Attenderth death sctor:	gţ	2 Accident S Pending Investigat			1 Yes 2 No			
Division of prints or Attending Phous after death peral Director: After filled in by the funeral	Certification:	3 Suicide 6 Could not determine	a l	ome, farm, street, facto	ory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rura ate)	al Route Number, City
Lospit t hour uners		4 Homicide	(Openity)			1		
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical	Check only	cian: To the best of my knowledger: On the basis of examination are	ge, death occurred at t nd/or investigation, in i	he time, date and place, a my opinion, death occurre	and due to the cause and at the time, date ar	 and manner as stated and place, and due to the 	d. cause(s)
To Sor	ĕ	29b. Signature and title of certifier	and manner stated.		9c. License number		29d. Date signed (Mont.	
		11 11.	V		O.C.M.E. 00M		December 18, 201	,
	1	30. Name and address of person who	complete bouse of death (Item	23a			,	
Ø,		Theodore M. King, Jr., MI			Penn Street, Baltim	ore, MD 21201		
Sta Registi		31. Date filed (Month, Day, Year) UEC 2 7 201	32 Registrar's Signatu	Sec. V.				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ MARY FRANCES HECKWOLF STAYLOR DECEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign al Security Number **Funeral** Months Hours 1 □ M 2 😿 F 216-07-2134 95 Mary land 1915 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No Maryland Baltimore County Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 715 Maiden Choice Lane USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 X Widowed 4 □ Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Spice Company Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary Otilia Ripple Theodore Michael Heckwolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PR) 4305 Conifer Court, Glen Arm, Maryland 21057 Mary Anne Heckwolf (Niece & 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State Green Mount Crematory 12/23/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatul of Functal Secure Local ee

Martin D. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.

801 timore Maryland 21212 York Road, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEV DO MONAS disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence on: if any, leading to immediate cause. Enter Underlying page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the attending physician and Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by ATRIAL FIBRILATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown CHADNIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 patient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred : After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

27 2010

DEC

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Sausnock AM 2010 9:55 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Center Baltimore Timonium 5. Social Security Number Year If Under 24 Hrs. 6. Sex If Under 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 14, 1 Months Hours Min 1 🔀 M 2 🗆 F 049 14 0480 Director 86 1924 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Examiner must be notified Maryland Baltimore Essex 1 🗆 Yes 2 😾 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 241 Orville Rd. 21221 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black White etc. 1 Never Married 2 Married 215-0036 If Yes, Give 1942/45 Year or Dates 1942/45 1 ☐ Yes 2 No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 72 N than Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. Forklift Operator Automobile Manufacturer 2 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or Harry Sausnock Mary Hoptak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Betty Teets (daughter) 708 Woodbridge Center Way Edgewood, Maryland 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 12/29/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue Essex, 23a.Phr.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest snock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death METASTA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of). s cian and Lurial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical phys. ttending pl IF FEMALE 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 L Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 🗌 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specif rector: After this by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and 29c. License numbe 29d. Date signed (Morth, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month, Day, Year) State Registrar

ODICIAIA

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G911 1/04/2011 Ih
The Danment of Health and Mental Hydiene

		1	For State Of Ma	-	artment of Heal tificate of Deat			eg. No,2 0 0	10598
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day 2010	3. Time of Death
	Medic	al .	Nancy Carol Schoff 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locat		December	4c. County of Deatl	4:35 A M
	Examin	C1	Gilchrist Center for Hospic	e	Towson			Baltimore	·
	Funeral Director		5. Social Security Nuclean 6. Sex 1 M 2 X F	e (In yrs. last birthday) 65 Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, 12/23/19	9. Birt Year) 945 Mary	hplace (State or Foreign Intry) Land
	and show at	l 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	Maryla 28a-f	irect	Maryland Baltimore	Middle					1 Yes 2 No
	s 23a or	Funeral Director	10e. Street and Number 1409 Shore Road		10f. Zip Code 21220			0g. Citizen of What Co	
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2 be notified at other traumatic event, the Medical Examiner must be notified at	ρ β	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent 6 Armed Forces? 1 Yes 2 Figure 19. Yes 2 Figure 19. Yes 2 Figure 19. Yes 3 Figure 19. Yes 4 Figure 19. Yes 5 Figure 19. Yes 4 Figure 19. Yes 5 Figure 19. Yes 5 Figure 19. Yes 5 Figure 19. Yes 6	No	Was Decedent of Hispani f Yes, specify Cuban, Me 1 ☐ Yes 2 🙀 No Spe		city Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: whi	e, etc.
21215-0036	72 hou "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during O NOT use retired)	most of worki	ng	16b. Kind of Business	Industry
212	within giene. er thar the M		Elementary/Seconday (0-12) College (1-4 or 9		ptionist			Hospital	
pue	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	To Be	17. Father's Name (First, Middle, Last) Benjamin F. Emkey		18. [Mother's Name Edna F	e (First, Middle, N Rođe	flaiden Surname)	
Maryland	ould b nd Mer mark		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and N	lumber or Rura	l Route Number,	City or Town, State, Zip	Code)
	and 2 sh Health a tem 27 is				9 Shore Roa	-			
Baltimore,	Page nent c ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Atlantic	natory or other place) Crematory L	LC 12/2	24/2010	20c. Location - City or Glen Burni	e, Maryland
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Incensee	22	2. Name and Address of I 407 Old Eas	Facility Bm	ızdzinsk	i Funeral	Home PA
	Physician/		23a Part : Enter the disease, o complications the cause shock, or heart failure. List only one cause on each lin Immeliaty Cause (Final disease or condition	d the death. Do not ent		ch as cardiac c			Approximate Interval Between Onset and Death
	Medical Examiner			a consequenty of):	4.				1
	red	Examiner	cause. Enter Underlying Cause (Disease or iinjury	a consequence of):					
0	cate be executed physician and the burial-transit	edical Exa	that initiated events resulting in death) Last C. Due to (or as	a consequence of):					
8760	ifficate ng phy as the	Medi	IF FEMALE:						
Box 68	res that the death certific signed by the attending d be detached for use as	Physician/M	23b. Was decedent pregnant 1 Live Birth	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
s, P.O.	ires that the signed by Id be detac	ρ	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in	Part I.	10	bacco use contribute to 'es 2 M√No 3 ☐ F	o the cause of death? Probably 4 Unknown
Division of Vital Records,	Attending Physician: The law requires that the death certificate be executed are death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Completed					24a. Was a autopo perfor 1 \(\superfor\) Yes	sy prior to med? death?	utopsy findings available completion of cause of s 2 \(\subsection \) No
tal	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?		100	of Death (Chec			11 - 121
of Vi	ing Physi fter this c	ate: To	1 ☐ Yes 2 ☑ No 1 ☐ Inpai 27. Manner of Death 28a. Date of inj (Month, Discontinuous) (Month, Discontinuous) (Month, Discontinuous)		of 28c. Injury at work?			ence 6 Other (Specow injury occurred	city) Hospico.
vision	or Attendi fter death irector: A n by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inbuilding, e	jury - At home, farm, st tc. (Specify)		2 🗆 No	28f. Location (Si City or Town	treet and Number or Ru n, State)	ural Route Number,
Ö	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of	avamination and/or invo	etication in my opinion de	eath occurred a	t the time, date ar	nd blace, and due to the	causesi and mariner stated
	To the I within 2 To the I complex	Me	(Check 2 Medical Examiner: On the basis of only one) 3 Certifying turse Practioner: To the 29b. Signature and title of certifier	e best of my knowledge,	death occurred at the time 29c. License nun			29d. Date signed (Mon	
			30. Name and address of person who completed cause of	death (Item 23a) (Type,	Δ Λ	140	A 0 A 11	12/24/ D 21200	;
Ψ.	Sta	te.	31. Date filed (Month, Day, Year) Regist	rar's Signature	4105 Bal	11000	3 14	0 21200	1
	عاد Registı		DEC 2.7 2010	. A. ba	les .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 005 Perin 0 010 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Howard County General Hospital Columbia Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. 10/19/1963 212-84-2954 47 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Ellicott City 1 Yes 2 No Howard MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ems 23a or r must be r Funeral 8418 Jopenda Dr 21043 USA items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Force Black, White, etc. 1 Never Married 2 Married ò þ 2 X No Ves Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced Completed White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government <u>Financial Systems Analyst</u> Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or attended. 18. Mother's Name (First, Middle, Maiden Surname) ျ Grace Ream Jay W. Seering, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8418 Jopenda Dr., Ellicott City, MD 21043 Bridgid Seering / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Hanover, MD 4 Donation 12/27/2010 5 Other (Specify) Ardent Cremation 22. Name and Address of Facility Harry H. Witzke's Fami y FH, Inc 21. Signat re f neral Se ic Lice e M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 ev 23a. Part 1. Inter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ 10/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 424 Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy after death.

Director: After this certificate To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Tes 2 **X**No 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pendina 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0027 Name and address of person who completed cause of ceath (Item 23a) (Type, Print) Ced4 141795 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:45 P.M Josephine E. Stangle December 17 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Stella Maris Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 290-14-0289 1 □ M 2 🗓 F Months Days Hours 94 Director /19/1916 Ohio Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 No Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 2300 Dulaney Valley Rd. 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black. White, etc. 9 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Special Functions Hospital Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Veronica Uhlenhake Frank Boeckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1737 Shakesphere Drive, BelAir, MD 21015 Judy Stangle Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 12/27/10 Dayton, OH Calvary Cemetery Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral ChapelP.A. ., Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Diserto for as a consecuence of Cause (Disease or linjury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical pe 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box that the death in the past 12 months?
1 Yes 2 No Month Year Dav Pregnant at time of death 5 ☐ Other (specify) 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No 24 hours after death. • Funeral Director: After this certificate P leted filled in by the funeral director, pag 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and titl 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) MANEY 2300 Registrar

DCCCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ULCIVAN ZVI U 4/46 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Tate Hospice House Linthicum If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖊 F Hours Min. Month, Day, Year) 07/04/1918 **Director** 199-03-5847 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 21146 U.S.A. 831 Ritchie Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Completed 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Magdelana Kringe David McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scituate, MA 622 Hatherly Road Mr. Michael Sullivan / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/08/2011 Richland Township, PA St. Isidores Cemetery 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Licensee Glen Burnie, MD Draves Halfield Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or year to line. Immediate Cause (Final Physician. disease or condition resulting in death) Medical ue to (of as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying During for es a consectiones of: Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy perform 1 \(\text{Yes} funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) HUSPICE THIE 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence After this HŒSE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. 🖊 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be within 24 hours after de

To the Funeral Directo

completed filled in by ti Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 MICHAE J.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brian Anthony T	•	State of Maryland / Department of 1-For State Certificate of Registrer			eg. No. 2010	0602
Physici Medical Exami		Decedent's Name (First, Middle,Last)	maulas	2. Date of Dea		3. Time of Death 2156 hrs
Medical Exami	IICI	Brian Anthony 4a. Facility Name (if not institution, give street and number)	$ ext{Taylor}$ 4b. City, Town, or Location of Death		4c. County of Death	
		Good Samaritan Hospital	Baltimore			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	rth(MM/DD/YYYY) 9. Bir -1987 Foreig	n MTD
- Director		213-19-5011 1 M 2 F 23 Yr Usual Residence of Decedent	s.	1-19	-1967 Co	untry) MD
any		10a. State 10b. County 10c. City, Town or Local				10d. Inside City Limits
Aaryland 28a-f show I at once.	jo	MD na Baltimo				1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 1154 E. Northern Parkway	10f. Zip Code 21239		0g. Citizen of What Cour	itry?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once			/as Decedent of Hispanic Origin? (Sp			can Indian, Black,
death or item must b	Funeral		Yes, specify Cuban, Mexican, Puerto		White, etc.	1
s after iral", o	by	3 Widowed 4 Divorced If Yes, Give Year or Details: 15. Decedent's Education (Specify only highest grade completed) 16a. Decede	Yes 24 No specify:	work done	Specify: B1	ack
7	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use reti		TOD. KING OF BUSINESS/I	industry
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21215-0036 sold be filed within 72 hours Mental Hygione. marked other than "natur c event, the Medical Exam	Be Co	17. Father's Name (First, Middle, Last) OtisTaylor		e (First, Middle, M Parro	Maiden Surname)	
ould be fill d Mental Figure 1 is marked tic event,	To E		ng Address (Street and Number or I			
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Baltimore, I bernit. Pages 1 and Department of Heal Important: If item injury or other tra		1 X Rurial 2 Cremation 3 Removal from State crematory or o	ther place)	27-10	Randalls	
Baltimore permit. Pages 1 Department of F Important: If injury or other		4 Donation 5 Other Specify:			East F/H	COWITY TIB
Perm Dep Dep		Joseph R. Walters	1101 E. North	Avenue	Balto,	MD 21202
Physician Medital		236. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac o	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease condition resulting in death) a Multiple Gunshot Wounds Due to (or as a consequence of):				Death
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Certification:	1 Natural 5 Pending Dec 17, 2010 2138 hrs	1 Yes 2 ✓ No	Subject sho		
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Spital spital cours a neral I		4 Homicide determined (Specify) Local Street			Lane, Baltimore, MD	
Division of Vital Records, P.O. Box 6876(To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence) Certifying Physician: To the best of my knowledge, death occurrence on the best of my knowledge, death occurrence on the best of my knowledge, death occurrence on the best of my knowledge, death occurrence on the best of my knowledge, death occurrence on the best of my knowledge, death occurrence of the best of my knowledge, death occurrence on the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of my knowledge, death occurrence of the best of th	irred at the time, date and place, and ation, in my opinion, death occurred a	due to the caus at the time, date	e(s) and manner as state and place, and due to the	e cause(s)
To wit	Me	29b. Signature and title of contifier	29c. License number		29d. Date signed (Mor	
X	i		O.C.M.E.		December 19, 20	10
OCME	1	30. Name and address of groon who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 11	1 Penn Street, Baltimore, M	ID 21201		
St	ate					18
Regist	rar	31. Date filed (Month, Day, Year) 10 32. Registrar's Signature for the state of the				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 15PM Thomas -BANCES 8 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALLIMORE FRANKTORA If Under 1 Year | If Under 24 Hrs last birthday) 8. Date of Birth (Month, Day, Un) 24 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No NIA Baltimore MD Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5009 21206 Funeral 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Black Specify. þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any injury or other traumatic event; the Medical once, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reisterstown daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune all Service Livensee 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably this certificate has been sral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be 1 ☐ Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 Pending 1 □ Yes 2 □ No investigation M 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed caus 8813 WAlthANWoods Rd #204

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State	State of M	aryland		artment of H		Mental Hy	giene	0 0001		
			Registrar 1. Decedent's Name (First, Middle, L	act	_	Cer	tificate of E	eath	2. Date of Dea	Reg. No. C. U	J -1 U D U 4		
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4			107-07-8384 Usual Residence of Decedent						Joun. 2	3,1314 (6	onnecticut		
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	eath v tems er mu	Funeral Director	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. V	Vas Decedent of Hi	spanic Origin? (S	pecify Yes or No-	14. Race - Am			
36	after d ", or i		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X If Yes, Give	No		Yes, specity Cubar		o Rican, etc.)	Black, Wh			
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Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lige	rsullo-							Chapel, P.A cyland21214		
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	monications that caused one cause on each line	the death.						Approximate Interval Between		
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_	sate be executed physician and the burial-transit	alE	resulting in death) Last	Due to (or as a	a conseque	ence of):							
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68 68	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	cy	Ectopic pregnancy	,		23d. Date of d	elivery		
Box	requires that the death certific been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown			Other (specify)	,		Month	Day Year		
P.O.	hat the ed by detacl	y Ph	Part II. Other significant conditions	contributing to death b	ut not resul	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?		
JS, I	uires t in sign uld be	Completed by	dementix a	trial fil	mla	4.07	mate	ral	1 🗆 ነ	/es 2 □ No 3 □ I	Probably 4 🗆 Unknown		
of Vital Records,	aw req as bee 2 sho	plet	Mmonary em	poli					24a. Was a		utopsy findings available completion of cause of		
Re	sician: The law certificate has l irector, page 2 s								perfor	med? death?			
ital	ysician: is certific director,) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:			Other	ce of Death (Che		1	46		
of V	ding Phys th. After this funeral di	e: To	27. Manner of Death	28a. Date of injur	y 2	R/Outpatient 28b. Time of	28c. Injury	4 ☐ Nursing F at		ence 6 Other (Spe	cify) Hospi CO		
o	ttendin death. ctor: Aft y the fun	ficat	1 Natural 5 Pending 2 Accident Investigati		, Year)	injury	M 1 □ Y	Yes 2 No					
Division	or Att after d Direct in by 1	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			ne, farm, stre	et, factory, office		28f. Location (S City or Town	treet and Number or Ri n, State)	ural Route Number,		
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowled	dge, death o	ccured at the time.	date and place. a	ind due to the call	ise(s) and manner as st	tated.		
	he Ho in 24 h he Fui ipletec	Medical	(Check 2 L Medical Exar	niner: On the basis of ex rse Practioner: To the	camination a	and/or investi	gation, in my opinior	n, death occurred :	at the time, date ar	nd place, and due to the	cause(s) and manner stated.		
	To the within 2 To the comple		29b. Signature and title of certifier				29c. License		^	29d. Date signed (Mon	th, Day, Year)		
	,		nk	cy u)	20-1/	Doc	7063	5	12/10/1	0		
	A		30. Name and address of person who			?3a) (Type, Pr > e S	int)	4106	Balt	mere up	2170		
	Stat		31. Date filed (Month, Day, Year)	32. Registra			2011	- (,,,,,,		- Co. Cy - VU)			
	Registra	ar	DEC 2.7 2010	augus A	1. 10	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARYANN I HOM DSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice LOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | 12-3|-(14-3) . Social Security Number **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 F Yrs. Director Usual Residence of Deceder 28a-f show 10b. County 10a. State 10c. City, Town or Location must be notified at Funeral Director Altimore MARY AND ö 10e. Street and Number 10g. Citizen of What Country? items 23a 2122 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other trammers. Elementary/Seconday (0-12) College (1-4 or 5+) MAIL ROOM CLURK Be 17. Father's Name (First, Middle, Last) မ SALVATORE Sophle 19a. Informant's Name/Relationship (Type, Print) 3529 Thompson -20b. Place of Disposition (Name of cemetery, crematory or other pl 20a. Method of Disposition ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State ren. 2- 59-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee Joseph N. 1 23a. Part 1. Entar he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No cate has been signed by the page 2 should be detached 9 Unknown g Unknown Completed by Records, 24a. Was an this certificate has 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: Natural Hospital or Attending I 24 hours after death. (Month, Day, Year) 5 Pending in 24 hours after death.
he Funeral Director: After pipleted filled in by the fun 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 9a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature ar 1500C person who completed cause of death (Item 23a) (Type, Print Name and address

14. Race - American Indian, 16b. Kind of Business Industry 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenton, ZANNINO Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 No 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 € Other (Specify, 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3. Time of Death

BAltIMORE

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 No

:480.M

(ana)

Registrar DHMH 17 Rev 7/2009

State

		•	For State of Ma	aryıan	•	ertificate of E				giene Reg. No	2010	40606	í
	Physicia	n/	1. Decedent's Name (First, Middle, Last) George Hartman Ving, III						2. Date of Dea		22, 2010	3. Time of Death	
	Medic Examin	-	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or	Location		Decemb		. County of Deat	th	-
	Francis		Gilchrist Center for Hospic 5. Social Security Number 6. Sex 7. Age		ast birthday)	Towson If Under 1 Year	If Unde	er 24 Hrs.	3. Date of Birt	h	Baltimo	thplace (State or Foreign	_
	Funeral Director		216-50-4840 1 ☑ M 2 ☐ F	62	Yrs.	Months Days	Hours	Min.	(Month, Day 02/02/	, Year) 1948	3 Mar	yland	
70	show	jo.	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo							10d. Inside City Limits	-
A CONTRACTOR	28a-f	irect	Maryland Baltimore	Mic	ldle R							1 ☐ Yes 2 🛣 No	
di A	23a or st be r	Funeral Director	10e. Street and Number 101 Lariat Road			10f. Zip Code 212:	20			-	tizen of What Co .S.A.	ountry?	
, decop	items ner mu		11. Marital Status 12. Was Decedent E Armed Forces?	4.0	6. 13.	Was Decedent of Hi		rigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Ame Black, White		_
5-0030	ral", or	Completed by	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ If Yes, Give Year or Dates.		967– 969	1 ☐ Yes 2🏋 No					Consider -	nite	
) -c	"natul edical	plete	15. Decedent's Education (Specify only highest grade completed)		(Give	edent's Usual Occupa kind of work done d	ation luring mo	st of working		16b. K	(ind of Business	Industry	I
717	tal Hygiene. Ital Hygiene. Ital Hygiene. Ital examiner must be notified at event, the Medical Examiner must be notified at		Elementary/Seconday (0-12) College (1-4 or 5	+)		ighter				Fire	e Depart	ment	
Yland 21215-0036		To Be	17. Father's Name (First, Middle, Last) George Hartman Ving, III	-				ther's Name (First, Middle,	Maiden Nor c		-	
S 3	ye i and z should be in it of Health and Mental it item 27 is marked or other traumatic ev		19a. Informant's Name/Relationship (Type, Print)		19b. Mail	ling Address (Street a						o Code)	
(if Health a item 27 is item 27 is other tra		Jeanette Ving (Wife)		-	Lariat Ro	ad,						_
nore	age of each of H		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	C	emetery, cre	osition (Name of ematory or other place Crematory		Da 12/23/			ocation - City or Limore -	Town, State Maryland	
Baitimor	Department of Important; If it any injury or o		21. Signature Juneral Service Licensee	Day		22. Name and Addres							-
מ מ	YQ F F P	-2	23a. Part 1 Enter the disease, or complications that caused	the death	- 1	<u>1407 old</u>	<u>East</u>	<u>ern Av</u>	enue,	Ess	ex, Mary	Tand 21221	1
P	n sician/		shock, or heart failure. List only one cause on each line Immediate Cause (Final	. C	Long	liver	407			est,		Approximate Interval Between Onset and Death	
	Medical xaminer		disease or condition sulting in death) a. Due to (or as a	consequ	ence :	1/1/4	Ula	Cyo				1101111	
		Jer	Sequentially list conditions, if a.y, leading to immediate cause. Enter Underlying	rui seçli	lende oty								_
Curred	nd transit	xami	Cause (Disease or iinjury that initiated events c										_
rou cate be executed	sician a burial-	edical Examiner	resulting in death) Last Due to (or as a	a consequ	ience ot);								
	ng phys		IF FEMALE:							Т			-
DOX O	attendi for use		23b. Was decedent pregnant in the past 12 months?	2 🗌 Feta	Ideath 3	Ectopic pregnanc	у				23d. Date of de Month	livery Day Year	
בי ה ה	by the tached	Physi	g Unknown										_
S, T,	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death be	ut not resi	ulting in the	underlying cause giv	en in Par	π ι.	23e. Did to		_	the cause of death?	
VITAL RECOLUS, vsician: The law requires	s been shoul	Completed							24a. Was		24b. Were au	topsy findings available completion of cause of	-
The la	cate ha								autop perfo 1 Yes	rned?	death?	s 2 No	
VITAI	s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes No Hospital:	ent 2 🗆	EB/Outpatie	26. Pla	er	eath (Check o		lence f	Other (Spec	HODICO	
ing Ph	oneral		27. Manner of D th 1 ☑ Natural 5 ☐ Pending 28a. Date of injur (Month, Day)	у	28b. Time o	of 28c. Injury work	at ?	28	d. Describe h		/		
DIVISION Palor Attendir	r death sctor: A by the f	Certificate:				M 1 L	Yes 2					ral Route Number,	-
<u> </u>	urs afte ral Dire		building, etc						City or Tow				
e Hosn	e Fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of a 2 Medical Examiner: On the basis of examiner on the basis of examiner: To the last of the	camination	and/or inve	stigation, in my opinio	n, death	occurred at th	e time, date a	nd place	e, and due to the	cause(s) and manner stated	d.
- Toth	withir To th	-	29b. Signature and title of certifier			29c. License	_				te signed (Monti		
			30 Name and address of person who completed cause of de	eath (Item	23a) (Type,	Print)	152	4	<i>V.</i>)+C)	ember	22 1010	_
1			HOSTING DOSCH GRI	P	OR	IN.Ch	GOK	rsst	Ta	250	nmi	21204	
	Stat Registra		31. Date filed (Month), Day, Year)	r's Signat	e had	ulil							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	le of Maryland		tificate of I			Reg. No. 201	0 40607		
	Physici	an	1. Decedent's Name (First, Middle, Last) Vincent J.	Vernac	chio			2. Date of Dea Month	Day Year	3. Time of Death 2.23 P M		
1	/Medic	al	4a. Facility Name (If not institution, give street ar		CIIIO	4b. City, Town, or	Location of Death	rec	19 2010 4c. County of De	·		
أمم	Examin	ier	St. Agres Hospi	I I		Ball +	imore					
	Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age (In yrs. Ia 85	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Jan. 5	9. Bi , 1925 Man	rthplace (State or Foreign Country) Cyland		
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Loc	ation				10d. Inside City Limits		
	e Mar	ctor	MD	Balti	imore				1 ¬Yes 2 □ No			
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code	10		10g. Citizen of What C	Country?		
	leath v	eral	2158 Harm@n Ave. 11. Marital Status 12. Was	Decedent Ever in U.S	5. 13. V	2123 Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	USA 14. Race - An	nerican Indian,		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a f show other traumatic event, the Medical Exportment must be notified at	þ	1 Never Married 2 Married	led Forces? Yes 2 □ No es, Give ror Dates: WW II		Yes, specify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	·		
15-0	72 ho "natur	etec	15. Decedent's Education (Specify only highest grade comple	eted)	16a. Deced	lent's Usual Occup	ation during most of work f)	ing	16b. Kind of Busines	s/Industry		
121	within iene. than be we	Completed	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)		k Driver	1)		BG&E			
pd 2	e filed al Hyg other vent, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surname)			
ylaı	should be filed vand Mental Hygies marked other tumatic event, In	To	Felix	Vernacchi			Thersa		alagala			
Mar	d 2 sho Ith and 7 is ma		19a. Informant's Name/Relationship (Type. Printerny E. Vernacchio (I		1		and Number or Rui re., Balt		er, City or Town, State,	, Zip Code)		
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition	20b. Pla	1	sition (Name of natory or other place		Date	20c. Location - City of	or Town, State		
imo	Pages ment of ant: If ite ury or o		1 Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State Loud	don Pa	rk Cemete	ery 12/23		Baltimore,			
Baltimore,	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Licence						rk Funeral more, MD 2			
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	e on each line.		er the mode of dyin		or respiratory ar	rrest,	Approximate Interval Between Onset and Death		
San Property	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		untender							
7	Examiner		Due to (or as a consequence m):									
	p tis	iner	Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a conseque	ence of):							
N	xecute and	Examiner	that initiated events c	ue to (or as a conseque	ence of):							
68760,	tificate be executed ig physician and as the burial-transit		d									
	E So a	Medical	IF FEMALE:									
. Box	death cer e attendin d for use a	Physician/	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnant Live birth 2 Petal Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	у		23d. Date of d Month	lelivery Day Year		
P.0	that the dended by the a	Phys	9 ☐ Unknown] Unknown	100		are by Dant I	OZo Did to	ahaaa uoo santributa	to the cause of death?		
Division of Vital Records,	The law requires that the death oe ate has been signed by the attending 2 should be detached for use	þ	Part II. Other significant conditions contributing	to death but not resul	iting in the un	nderlying cause giv	en in Paπ i.			Probably 4 Unknown		
Seco	e law re has be le 2 sho	Completed						24a. Was autop		autopsy findings available o completion of cause of		
alF			25. Was case referred to medical				00 Plans of Pass	1 □ Yes	2 ØNo 1 □ Ye	es 2 100		
<u>=</u>	S S =	To Be	examiner? 1 Yes 2 No Hospital:	1 ☑ Inpatient 2 ☐ E	ER/Outpatien	t 3 DOA Oth	er: 4 ☐ Nursing He		<i>ine)</i> dence 6 ∐Other <i>(Si</i>	pecify)		
n of		on:T	27. Manner of Death 28a. 1 ☐ Natural 5 ☐ Pending		28b. Time of Injury		y at k?	28d. Describe I	now injury occurred			
isio	Attending r death. ector; Afte by the fune	Certification:	2 Accident investigation	Place of Injury - At hor building, etc. (Specify,	me, farm, stre		Yes 2□No	28f. Location (S	Street and Number or	Rural Route Number,		
<u>≥</u>	s after at Dire	Certi	4 Homicide	building, etc. (Specify,)			City or Tov	vn, State)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical	29a. Certifier 1 Certifying Physician: 2 Medical Examiner: On one)									
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1 max	dica	29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)		
	, ,) V	7 Pes	siden	1 12	4051		12 (19)	10		
	3/1		30. Name and address of person who completed		_	uton A	ve, Bo	ultire	one, M	0 21229		
	Sta		31. Date filed (Month, Day, Year) OFC 2.7 2010	32. Registrar's Signati	ure							

DHMH 17 Rev 1/2001

Vernacchio, vincent

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Annette Louise Warren 02:48 A M DECEMBER 2010 Medical 4c. County of Death Baltimore 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** OW SON SAINT JOSEPH MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** (Month, Day, Yea 10/6/51 59 Days Hours Min. 1 M 2 DXF 214-58-5606 Director МD Usual Residence of Decedent Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland **Funeral Director** N/A MD Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5632 Clearspring Road 21212 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces African Specify Amer. 1 Never Married 2 Married Completed by 1 ☐ Yes 2x No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 🗌 Widowed 4 🔀 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Hospital Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Henry Coleman, Sr. Carrie Cooke . Page 1 and 2 should be iment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 Kenisha Warren/Daughter 16 Valleylake Place, Cockeyville, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Carmel Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite 1 Neurial 2 Cremation 3 Removal from State injury or 12/29/10 Balt.,MD Mt. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. 21. Signature of Fune: | Service | censee 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA Medical resulting in death) Due to (or as a consequence of Examiner YEARS MMUNOSUPPRESSION Sequentially list conditions, Physician/Medical Examiner If any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events RENAL TRANSPLANT resulting in death) Last YPERTENSIVE KIDNEY DISEASE Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed' 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

MD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. BRINKER

31. Date filed (Month, Day, Year)

DEC 27 2010

D51852

7601 OSLER DRIVE

29d. Date signed (Month, Day, Year)

TOWSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day ELORES 5-30P M **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)

Mary and Social Security Number Funeral Min 34-8761 1 □ M 2 🕱 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State other traumatic event, the Medical Evandrer must be notified at 1 X Yes 2 □ No Funeral Director timor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe e 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No 2 3 ₩ Widowed 4 □ Divorced Blac Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. (Pant) (brother) Department of Health ar Important: If Item 27 is any Injury or other trau stown solomon 20c. Location - City or Town, State 20b. Place of Disposition cemetery, crematory Date 20a. Method of Disposition Number | 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph L. Russ Funeral Ho 2222 W. North Ave. Balto. Home 23a. Part 1 / Enter the dise of complication of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHERO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye ar in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown יייסי עווא כפרעוווcate has been signed I funeral director, page 2 should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available autopsy performe prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 1 TYes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signafure and title of certifier 100011 30. Jame and address of person who completed cause of death (Item 23a) (Type, Print) BALTO MID SMITH 31. Date filed (Month, Day, 32. Registrar's Sgnature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CQUELINE 530 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Severn Anne Arundel 548 Jones Road Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 29, 1963 Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 📆 F Days Hours Min. Country) Virginia Director 212-86-4612 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Severn Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 548 Jones Road 21144 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 9 þ 1 Never Married 2 X Married ☐ Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify. Black "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) J. C. Penny the Cosmologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louvenia Stevens Abner Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 548 Jones Road Severn, Maryland 21144 Keith Williams 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or other 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/22/10 Hanover, Maryland 4 Donation 5 Other (Specify) St. Rest Cemetery Sig neral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 2 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician UNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or linjury that initiated events the burial-transi that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal dear 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) detached g Unknown g 🗌 Unknown P.O. tuneral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 2 ☐ No 3 ☐ Probably 4 😿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate 1 ☐ Yes 2 ☐ No 2 XN or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29c. License number

Registrar

State

HAEL

31. Date filed (Month, Day, Year)
DEC 2 7 2

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

E

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32. Registrar's Signature

202010

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		For State Certificate of Death		. No.	
Physicia		e gistrar I. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death
cal Exami	-	Paula Sue Waterbury	December	16, 2010	1210 hrs
vai Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deatl	1
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	_	1Forei	n n
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	F	Usual Residence of Decedent			
any		10a, State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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and	ō L	Maryland Baltimore 10f. Zip Code	10	g. Citizen of What Cou	ntry?
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ould ould I Me	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	CI	Del, City Of Town, Cita	o, 2.p oods,
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Pag ment					
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Market of the contract of the Market of the Mar		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	arzullo	Funeral	Chapel, P.
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	Sa	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d at the time, date	and place, and due to	the cause(s)
Tot Tot com	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed ()	Month, Day, Year)
	-	O.C.M.E.	VE	December 20,	2010
		The day Mr. Krt Styred.			
1		30. Name and address of person who completed base of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltime	ore MD 2120	1	
4		Theodore III. Twig, etc., in	UIE, IVID 2 120	-	
	Verte	31. Date filed (North Day Year) 32. Registrar's Signature			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24^{Day} Physician/ Carrie Dodrer Wagner 2010 8:30A M Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center Social Security Number MD Country) 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year) 12-26-1917 213-05-3835 1 □ M 2 🛣 F Hours 92 **Director** Usual Residence of Decedent Show or 28a-f shov notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Westminster MD Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 320 Bell Rd. 21158 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Clothing Elementary/Seconday (0-12) College (1-4 or 5+) the Seamstress 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Belle Irene Strevig Joseph Abram Dodrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Bell Rd., Westminster, MD 21158 R. Verl Wagner-husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadow Branch Cem 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Westminster, MD 12-30-10 4 Donation 5 Other (Specify) 21. Signature of Filneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Main St. Westminster, MD 21157 \mathbf{E} 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Days Immediate Cause (Final Ph sician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Days Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery hed for I in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by t should be detach ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Coronary Artery Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has performed certificate 1 Yes 2 No 2X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 🔀 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) D38915 12/24/10

State Registrar

DHMH 17 Rev 7/2009

295 STONER AVE, WESTMINSTER, MD 21157

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

MD

FRENTI

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physician Medica Examine **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any joines. To Be Completed by Filneral Director DECEMBER 21, 2010 12:45 a.m. Baltimore, Maryland 21215-0036 hysician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 MARY WATKINS

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	Decedent's Nam								2. Date of Dea Month Decemi		21, Year 201	3. Time of Death
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2 2 2 2	11. Marital Status 1 ☐ Never Mari 3 🍽 Widowed		rried	12. Was Deced Armed Ford 1 Yes If Yes, Give Year or Dat	2 XNo	'	Was Decedent of Hispa If Yes, specify Cuban, M 1 ☐ Yes 2 ※No S	Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: W	
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	21. Signature of Fu	ineral Service	Ligense	$^{\circ}\mathcal{D}$.	+ /		2. Name and Address of					
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						-			24a. Was a autop perfor		prior to	atopsy findings available completion of cause of
-	25. Was case referr	red to medical	\neg	 			26. Place	of Death (Check		2 A N	lo 1 ∐ Ye	s 2 No
	examiner? 1 Yes 2	X No	H	lospital: 1 ☐ li	npatient 2 🗆	ER/Outpatier	nt 3 DOA Other:	4 Nursing Ho	me 5 Resid	ence (6 🛚 Other (Spec	cify) HOSPICE
	27. Manner of Deat 1 X Natural 2 Accident	5 Pendi Invest	igation	28a. Date o (Month	f injury , <i>Day, Year)</i>	28b. Time of injury	work?	s 2 🗆 No	28d. Describe h	ow inju	ry occurred	
	3 ☐ Suicide 4 ☐ Homicide	6 Could detern			of Injury - At ho g, etc. (Specify		eet, factory, office		28f. Location (S City or Town			ıral Route Number,
	(Check 2	2 Medical	Examin	er: On the basis	of examination	and/or inves	occured at the time, da tigation, in my opinion, death occurred at the tir	death occurred at	the time, date ar	nd place	e, and due to the	cause(s) and manner stated.
	29b. Signature and	title of certific	VIZ.	CAN	P		29c. License nu	mber 9792		29d. Da	ate signed (Mont	h, Day, Year)
	30. Name and add		who co					тмонти	Mm of	002	 	
	JACKIE 31. Date filed (Mon		_UKI	32. Re	gistrar's Signa	ure Sala	LEY RD. J	TMONTUM	, FW / L	UYJ		
	DEC 27	7 2010		ANKALT.	la. (1)							

DHMH 17 Rev 7/2009

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State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 406 4 State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	,	Certificat	e of De	eath		F	teg. No.				
Physician/ 'ical Examiner	1. Decedent's Name (First, Midd						2. Date of De Month December	ath Day Yea er 19, 2010	3. Time of Death 1139 hrs			
	4a. Facility Name (if not institution 2505 Old Field Point		r)		ity, Town, or Lo Ikton	ocation of Dea	ath	4c. County of	of Death			
Funeral Director	5. Social Security Number		age (In yrs. last birthd	M	Under 1 Year Ionths Days	If Under 24H Hours N	irs. 8. Date of B		9. Birthplace (State or Foreign Country) PENNA			
	222-46-8008 Usual Residence of Decedent	1 M 2 F	47	Yrs.			12-0-	-1903				
w any	10a. State 10b. County		10c. City, Town or						10d. Inside City Limits 1 X Yes 2 No			
Aaryland 28a-f show 1 at once. ector	PENNA LEHI(GH	ALLENT		f. Zip Code			10g. Citizen of Wh				
death with the Maryland or items 23a or 28a-f sho must be notified at once. -uneral Director	326 N. 8th S	Γ.			18102	2		USA				
er death with t , or items 23s r. must be not Funeral	11. Marital Status 1 Never Married 2 X	12. Was Deceder	s?		cedent of Hispa pecify Cuban, I		Specity Yes or N rto Rican, etc.)	0- 14. Race White	- American Indian, Black, e, etc.			
safter de iral", or niner my by Fu	3 Widowed 4 Di	1 Yes vorced If Yes, Give Yeer or Dates:	2 X No		2 X No			Specify:	WHITE			
hours Fram	15. Decedent's Education (Spe Elementary/Secondary (0-12)		du		sual Occupation of working life. D			16b. Kind of Bus	siness/Industry			
5-0036 ed within 72 hour 1/9 giene. other than "natu the Medical Exan Completed	-12-	-0-	· .	LABOR	ER			CARE	PENTER			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 23a-f sh injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	17. Father's Name (First, Middle JOHN WALLS	, Last)			18		me (First, Middle, COTHEA CO	Maiden Surname)				
MD 21 32 should 1 th and Mer a 27 is mar umatic ev	19a. Informant's Name/Relation								n, State, Zip Code)			
e, M and 2 Health sitem 2;	ALICIA L. WAT		20b. Place of I	Disposition	(Name of ceme		Date	PENNA 181 20c. Location -	City or Town, State			
MOF Pages 1 tent of 1 int: if		n 3 Removal from Specify:	METRO		TORY				ORE, MARYLAND			
Baltimore, remit. Pages 1 ar bepartment of Hei important: Wite inportant: Wite injury or other tr	21 Signature of Funeral Service	Licensee JONATHA	N D. HIBN									
Physician	239. Part I. Enter the disease, o							PENNA I rest, shock, or hea				
/Medicul ∈xaminer	failure. List only one cause in mediate Cause (Final disease	_{a.} Contact Gunsl		ead					Death			
	of condition resulting in death) Sequentially list conditions,	Due to (or as a con										
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c										
recuted t and transit	events resulting in death) Last	Due to (or as a cond.	sequence of):									
2. ਙ ਛੋ ਫ	UNPENDED	AMENDED						Locus				
68760, ertificate be ding physici e as the buri	IF FEMALE: 23b. Was decedent pregnant in to past 12 months?	the 1 Live birth	ome of pregnancy	Fetal de		Ectopic preg	nancy	23d. Date of Month	Day Year			
). Box 687 the death certific by the attending lached for use as the	1 Yes 2 No 9 Ur	4 Pregnant and Pre	at time of death 5	Other ((Specify)							
P.O. Es that the digneral by the detached	Part II. Other significant condi	tions contributing to dea	ath but not resulting i	n the under	rlying cause giv	en in Part I.	23e. Did		bute to the cause of death? Probably 4 Unknown			
w requires to w requires to should be consignated to pleted the	-						24a. Was	an 24b. V	Vere autopsy findings available			
Records, The law requires ficate has been sig page 2 should be Completed	· · · · · · · · · · · · · · · · · · ·		,				_ auto perf 1 ✓ Yes	ormed? d	eath? Yes 2 No			
Vital Rec ysician: The l his certificate I director, page o Be Corr	25. Was case referred to medici examiner?	Unanitali			<u> </u>	of Death (Che		1- //				
n of Vi ding Physi h. After this funeral dir	1 Yes 2 No 27. Manner of Death	28a Date of Ir	niury 28b Tir	ne of Injury			28d. Describe	Residence 6 how injury occurre				
ision (Attendin er death. rector: A by the fur ication		FOUND: Dec 19, 201			1 Ye	es 2 🗸 No	Subject sh					
Division of Vital Records, P.O. Bopital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by stely filled in by the funeral director, page 2 should be deated all Certification: To Be Completed by F.	3 ✓ Suicide 6 Cou	ıld not be 28e. Place of	Injury - At home, farm ingle Family Ho		ctory, office bui	ilding, etc.	or Town,		er or Rural Route Number, City Elkton, MD			
8 4 2 2 8 8 8 8 8 9 8 9 8 9 8 9 8 9 8 9 8 9												
To the within To the comple	29b. Signature and title of certifi	and manner state	d		29c, License				ed (Month, Day, Year)			
	() Card	rlead	>		O.C.M	I.E.		December	20, 2010			
	30. Name and address of person Laron Locke MD.	n who completed cause of Assistant Medical E		Penn Str	reet, Baltim	ore, MD 2	1201		i d			
State Registrar	1 1 for 4 " " 9.8 " / " 1	32. Regist	rar's Signature	O Man	,							
DHMH 17 Rev 1/2001	00		ORIO	GINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylane					/lental Hyตุ	giene			
			State Registrar		Cer	tificate	of Dea	th	1	Reg. No.	2011	1,4061	0
	Physicia	n/	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Year	3. Time of Death	v/I
	Medic		Sun Ok Yoon 4a. Facility Name (if not institution, give si	treet and number)		4h City To	own or loca	ation of Death	Dec. 13		County of Dea	2:55 P	-
	Examin	er		15			Burn			40.	Anne A		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1	Year If U	Inder 24 Hrs.	8. Date of Birt		9. B	irthplace (State or Foreig	ın
	Director		210-21-7327	76	Yrs.	IVIOIILIIS	Days 110	urs IVIIII.	Feb. I	9',1	934 K	ountry) orea	
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation						10d. Inside City Limit	s
	laryla 3a-f s iffied	Director	Maryland Anne Aru	ndel Gle	n Burn	ie						1 🗆 Yes 2 🛣 N	10
	or 28		10e. Street and Number			10f. Zip 0	Code	-		10g. Citi	zen of What C	Country?	
	s 23a	Funeral	1420 Crain Hwy., S	.W. #15		2106	61		1	Unit	ed Sta	tes	
	death item ner n		The trial of the control	12. Was Decedent Ever in U.S Armed Forces?		Vas Deceder Yes, specif	nt of Hispani y Cuban, Me	ic Origin? (Spexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi		
36	after al", or xami	d by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give	1	☐ Yes 2	☑ No Sp	ecify:			Specify: As		
9	hours hatura ical E	Completed	15. Decedent's Edu		16a. Deced	ent's Usual	Occupation		ī		nd of Busines		
2	in 72 le. nan "r	omo	(Specify only highest grad Elementary/Seconday (0-12)		(Give k	ind of work NOT use n	done during	most of work	ing			-	
7	l withi ygiene ner th t, the			College (1-4 or 5+)	Homem	aker				0	wn Hom	e	
gu	e filec ad ot even	To Be	17. Father's Name (First, Middle, Last)					Mother's Nam	ne (First, Middle,	Maiden S	Surname)		
Maryland 21215-0036	d Mer d Mer mark matic		Young Bin Yoon 19a. Informant's Name/Relationship (Typ	a Printl		4.1.1				0"		7' · O · d ·)	
Ma	2 sho Ith an 27 is 'traui		Jouang Ja Eichorn	•					al Route Number 303. G1	-		MD 21060	
ē,	f Hea item other		20a. Method of Disposition	20b. Pl	lace of Dispos	sition (Name	of					or Town, State	_
altimore,	Page nent o int: If ry or		1 ☐ Burial 2 🖾 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	icinoval ironi otate	emetery, crem cro Cre	-		c Dec	15,	Cato	nsvill	e, Maryland	1
ati	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign sure of suneral service Licer see	• ·	22	Name and	Address of F	Facility Fun	neral Ho	.m.o	ЪΛ		_
8					42	l Cra	in Hw	y. SE;	Glen E	urni	e, MD	21061	
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one	cations that caused the death cause on each line.	. Do not ente	r the mode	of dying, suc	ch as cardiac	or respiratory arr	est,		Approximate Interval Between	
	Ph_sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	ne to	stata	5	Mar	na	1) Lu	1		Onset and Death	- 1
an south	Examiner		resulting in death)	Due to (or as a consequ	ence of):				J				
		Jer	Sequentially list conditions,	Dun to for ea a consecu	once off:					/			
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events										
	exect an an rial-tr		resulting in death) Last	Due to (or as a consequ	ence of):								
9	cate be executed physician and the burial-transit	edical		i									
387	artifica ding p ie as t	/Me	IF FEMALE:	3c. If yes, outcome of pregnar	acv								
Box 68	ath ce attend for us	Physician/M	in the past 12 months?	1 Live Birth 2 Fetal	I death 3 🗌	Ectopic pro				1 2	23d. Date of d Month	elivery Day Year	
m m	he de y the ched	hysi	1 Yes 2 No 9 Unknown	9 Unknown									
Division of Vital Records, P.O.	that t ned b e deta	by P	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying ca	use given in	Part I.	23e. Did to	bacco u	se contribute t	to the cause of death?	
ds,	quires en sig ruld b	ted l							1 🗆 🕆	Yes 2	□ No 3 🔀	Probably 4 🗌 Unknow	/n
Sor	aw rec as be 2 sho	Completed							24a. Was a		prior to	utopsy findings available completion of cause of	9
Ř	The la	Con							perfo	rmed? 2 No	death?	es 2 No	
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	ospital:			26. Place of Other:	f Death (Chec	k only one)				
<u> </u>	Phys this cral dir	10	1 ☐ Yes 2 🗓 No	1 ☐ Inpatient 2 ☐ I	ER/Outpatien 28b. Time of		c. Injury at	T	ome 5 X Resid			ecify)	_
Ē	ding th. After fune	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	м	work?		200. Describe II	OW HIJULY	occurred		
SIC	Atter er dea ector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor	me, farm, stre	et, factory,	office				Number or R	ural Route Number,	
2	tal or rs aft al Dir			building, etc. (Specify)				9	City or Tow	n, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examina	cian: To the best of my knowle er: On the basis of examination	and/or invest	igation, in m	y opinion, dea	ath occurred a	t the time, date a	nd place,	and due to the	e cause(s) and manner sta	ited.
	thin 2 the 1 the 1	Me	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of my	knowledge, d	1	ed at the time License num				and manner a e signed (Mon		_
	F ≥ F 2		1/5/	2019									
	.\ /		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, P.		31551			лес.	14, 2	.010	_
	HV		Russell DeLuca, N	1.D. 305 Ho	spital		Glei	n Burn:	ie, MD	2106	1		
Ü	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signar	arkel							-	
	Registra	Tr.		/ I									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZINGARELL Year 20/0 Physician/ ONS FANCE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and pumber) 4b. City, Town, or Location of Death **Examiner** UNDALK TROPE 8. Date of Birth (Month, Day, Year) 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔼 F Months Hours Min. Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No MORC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8101 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status Armed Forces þ 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify. If Yes, Give Specify. 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratifed) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) LAPPESSIONS OF LOVE Elementary/Seconday (0-12) College (1-4 or 5+) hot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8101 ORNIVA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) EM 2010 21. Signature of Funeral Service Licensee 100 2/229 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line , or complications that caused the death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury for use as the burial-transi-Physician: The law requires that the death certificate be executed cat has been signed by the attending physician and pege 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.0. Part II. Other significant conditions co 23e Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No After this certificat 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one, XNo Hospital ပ 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 5 Pending 2 🗆 No death. 2 Accident 3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 31. Date filed (Month, Day, Year,

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arka

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country Nest Afric Age (In yrs. last birthday) 8. Date of Birth 1939 (Month, Day, Year) **Funeral** 1 **X**M 2 □ F Months Days Hours 214-65-2248 Yrs. 71 Ondo,Nigeria September 29, **Director** Usual Residence of Decedent the Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Director Prince Georges Maryland Bowie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code with ō "natural", or Items 23a or 9915 Chessington Way 20721 United States permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X**No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married altimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2X No Specify 2 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) years Banker Afrik Bank of Nigeria 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Josiah Awosika Sarah Olayinka Ajike မ 19a. Informant's Name/Relationship (Type. Print)
Cecilia Adenike Olojo Awosika(wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arinola Gabrielle Awosika (daughter) 10538 Storch Drive; Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ;January Cate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) N. Horton Company Morticians, Signature of Funeral Service Name and Address of Facility Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** hight hear volume overloo disease or condition resulting in death) /Medical Due to (s a consequence of) Examiner Mostral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Year Day 5 Other (specify) 2 No detached P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has after death.

Director: After this certificate 2□No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation (Month, Day 2 Accident 1 Tyes 2 □ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide the Hospital within 24 hours a 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 DECEMBER 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARSH 600 North Wolfe St, Baltimore, MD, 21287 mr 32. Registr 31. Date filed (Month, Day, Year) State DEC 0 9 2010 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 \mathbf{p}_M 2010 Alexander, Jr. 8:20 Charles Raymond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 6356 Goral Court Waldorf 7. Age (In vrs. last birthday, If I Inde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Hours Min. (Month, Day, Yea 06/21/194 Washington, DC Director 578-56-5282 68 Usual Residence of Decedent 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Goral Court 20603 6356 IISA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates. "natural", Specify: 3 Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Armed Security Guard Private Security marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Raymond Alexander, Sr. Mary B. Suber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Lillie Alexander - Wife 6356 Goral Court Waldorf, MD 20603 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🗵 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 12/10/2010 Lincoln Cemetery Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of FacilityFt. Lincoln Funeral Home, longa Montgomeny 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Lung C A which metastaisized to brain Physician/ disease or condition months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin and -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year the g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed Hypertension Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) the Funeral Director: After thi mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 5 \square Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier ucas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Month Edgar Aikens 55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fairney Keed Boonsboro, MD Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F April Day Year West Virginia 83 Director 216-22-9647 1927 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 28a-f s 1 🗌 Yes 2 🗓 No Boonsboro Maryland Washington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 21713 U.S.A. 8507 Mapleville Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin 1 X Yes 2 No 1945-If Yes, Give Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 1946 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State Government Maintenance Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virgie Mae Walters Charles Edgar Aikens, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9223 Cool Hollow Terrace Hagerstown, MD Charles D. Aikens / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Boonsboro Cemetery 12/07/2010 Boonsboro, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 23a. Part 1. Inter the disease, or complications that codeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due o (or as a consequence of) **Examiner** years Sequentially list conditions, Examine cause. Enter Underlying attending physician and for use as the burial-transit uear Cause (Disease or iinjury Arteny that initiated events resulting in death) Last uears Non-Hodakins Lymphoma Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death g Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it or Attending Physician: Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R128088 Kate M Smith CRNP OF December 3, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7+1 Kate M. SMITH CRNP 1126 opal Ct. Hagerstown, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 T M 2010 10 WAC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata Charles tuspita Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 TKF Months Hours Min (Month, Day, Year) 2-10-65 Virginia Yrs. Director 579-92-7516 Usual Residence of Decedent FAITH "HROGE permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4093 Bluebird Dr 20603 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Johnnie King Jr. Juanita Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4093 Bluebird Dr. Waldorf, Maryland 20603 Dasha J. Brown/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem.Garden12-14-10 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral HomePA, Aquasco MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final NIVO Ca-Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) by the a ☐ Yes ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: performed 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 🗹 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? I Director; After the din by the funeral 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 713 10 MD old 1 7801 Branch 20735 31. Date filed (Month, Day, Year State DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician/ Month Margaret Ann Dec 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death 4c **Examiner** Queen Anne Grasonville Terrace Grasonvi If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. | Month, Day,
OCT. 31 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕡 F **Director** Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No rasony 10g. Citizen of What Country? 10f. Zip Code 72 hours after death with the 10e. Street and Numb Funeral Grasonville 216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 \square Never Married 2 \square Married 1 ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Blac Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eli Zabeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai 1gh man A Tonya 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City of Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery rrasonville, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Henry Funeral
510 Washing 21. Signature of Funeral Service Licensee Shington 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be each hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant a
9 ☐ Unknown n signed by the a Id be detached f 1 ☐ Yes 2 ☐ Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home Statement 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1. Natural work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. HO0 579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WERE Godman, DO 31. Date filed (Month, Day, Year) State DEC 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 28 Physician/ Month Year Creswell Baranek 10:12 PM November 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Regional Hospital Laurel Laurel Prince 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2🛣 F Days Hours (Month, Day Year 2-5-1931 Washington, 79 220-26-6783 Director Jsual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Berwyn Heights 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8710 Edmonston Rd 20740 United States er than "natural", or items 23 the Medical Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. <u>5</u> 1 Never Married 2 Married 1 Yes 2 X No Specify. should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes, Give Specify: White 3X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Knorr permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Eleanor Bristow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Holladay (Daughter 15605 Peach Orchard Rd. Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Fort Lincoln Cemetery 12/3/2010 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funer Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home jiances 3401 Bladensburg Road Brentwood, MD 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - Preumonia Aspiration disease or condition resulting in death) Due to (or as a consequence of) Respiratory Sequentially list conditions. Examine fl. a. y, leading to himediate cause. Enter Underlying for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

72 hours after

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician ate has been signed by the a page 2 should be detached to within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director,

Be

မ

Certificate:

Medical

29b. Signature and title of certifier

Date filed (Month, BEC 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shapiro

Division of Vital Records, P.O. Box 68760

Diabetes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Chronic Obstructive Pulmonary Disease 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: 2 X No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

29c. License number

119313

Laurel Regional Hospital, Emergency

29d. Date signed (Month, Day, Year)

Laurel, MD

Registrar DHMH 17 Rev 7/2009 filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

. Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked ot

Part II. Other significant conditions	s contributing to death but not	23e. Did tobacco us	se contribute to the cause of death?						
Bronchopulmo	nary Dysplasi	1 ☐ Yes 2 🕽	¶No 3□ Probably 4□ Unknowr						
Intraventri	cular Hemorrh	∃ge		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No				
25. Was case referred to medical			eath (Check only one)	(Check only one)					
examiner? 1 ⊠ Yes 2 ☐ No	Hospital: 1 Inpatient	ER/Outpatient 3 ☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	Other (Specify)				
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day, Yea	r) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 Suicide 6 Could not determine		At home, farm, street, fac pecify)	tory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	Physician: To the best of my				and manner as stated.				

State Registrar

completely

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ABBULKAD

7 2010

Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 Hospital Dr., Cheverly, MD 20785

29c. License number

00066 498

29d. Date signed (Month, Day, Year)

11-25-2010

Regis

and manner stated

3. Time of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

2

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

FRED		BL	ACKMON		DECEMBE!	9:00 A _M			
4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	r Location of Death		4c. County			
14618 Cambridge	Drive		Upper	Marlboro		Princ	ce Ge	orge's	
Social Security Number 6	S. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Coun	ace (State or Foreign try)	
422-16-0982	92	Yrs.			Feb 15,	1918	Ala	bama	
Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Loc	eation				10	Od. Inside City Limits	
,								1 ☐ Yes 2 ☑ No	
	e George's	Uppe	er Marlbo	ro	10	g. Citizen of V	What Coun	**	
10e. Street and Number	D !			20	10				
14618 Cambridge	Drive 12. Was Decedent Ever in U	C 12 M	2077		pacity Vac or No-	Unite	e - Americ		
11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	.s. 15. V	Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		k, White,	etc.	
3 StWidowed 4 ☐ Divorced	d 1 X]Yes 2 □ No If Yes, Give VIETN Year or Dates: ERA	IAM- 1	☐ Yes 2XNo	Specify:		Specify			
15. Decedent's	Education	16a, Decede	ent's Usual Occup	pation	1	6b. Kind of Bu		k/white) _{Hustry}	
(Specify only highest	grade completed)	(Give k	kind of work done OO NOT use retire	during most of world)	king				
Elementary/Secondary (0-12)	College (1-4or 5+)	Ser	geant			US M	ilita	rv	
17. Father's Name (First, Middle, La	ast)		-	18. Mother's Nam	ne (First, Middle, M			-	
David McMur	phy			Durvie	Blackm	on			
19a. Informant's Name/Relationship	p (Type. Print)	19b. Mailing	g Address (Street	and Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)	
Durvie Blackmon 1	Bias/daughter	14618	Cambrio	ge Drive	Upper Mar	rlboro	, Mar	yland 2077	
20a. Method of Disposition	20b. I		sition (Name of natory or other pla			Oc. Location -	•		
1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe	3 Hemovai from State				/11/2010 1	Moodhi	00 M	aral and	
21. Signature of Funeral Service Lie					on Service				
Juanita R	Homas MOO!	957 Be	oing Home everly L.	Heckrott	on Servic	e P.O. Clarks	вох ville	/84 •, MD 21029	
23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the deat	th. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory arres	st,		Approximate Interval Between	
Immediate Cause (Final			arte nementenana visca					Onset and Death	
disease or condition resulting in death)	a. ATHEROSCLER Due to (or as a consec		ARDIOVAS	CULAR DIS	EASE		-		
	320 10 (0. 20 2 00.1000	1401100 01/1							
Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	uence of):							
Cause (Disease or injury that initiated events	C								
resulting in death) Last	Due to (or as a consec	quence of):							
	d								
						-			
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn		lEctopic pregnanc	.,		23d. Da	te of delive	ery	
in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a		Other (specify) _	· · · · · · · · · · · · · · · · · · ·		Month Day Year			
9 ☐ Unknown	9□ Unknown								
Part II. Other significant condition		ulting in the un	iderlying cause gi	ven in Part I.	23e. Did tob	acco use cont	ribute to th	ne cause of death?	
ATRIAL FIBRILLA	TION				1 □ Ye	s 2□ No	3 ☐ Prob	ably 4 □Unknown	
DEMENTIA					24a. Was an	24b.	Were auto	psy findings available	
					autopsy perform	ned?	death?	mpletion of cause of	
25. Was case referred to medical				OR Place of P		-4.2	1 ☐ Yes	2[] No	
examiner? 1 Yes 2 XNo	Hospital: 1 Inpatient 2	ER/Outpotion	t 3 DOA Oti	ner:	th (Check only one		Or /O	5-1	
27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inju	4 Li Nursing H	ome 5 X Resider 28d. Describe hor		_ ` ' _ '	у)	
1 Natural 5 Pending		Injury		rk?]Yes 2∐No		, . ,			
3 Suicide 6 Could no	ot be 290 Blood of injury At h	ome, farm. stre			28f. Location (Str	eet and Numb	er or Rum	al Route Number.	
4 ☐ Homicide determin	building, etc. (Speci	fy)	.,,, 0,1100		City or Town,	, State)			
29a. Certifier 1 A CertifyIng	Physician: To the best of my kn	owledge death	occurred at the t	ime, date and place	and due to the ca	nuse(s) and m	anner as s	tated.	
(Check only 2 Medical Ex	xaminer: On the basis of examinand manner stated.	ation and/or inv	vestigation, in my	opinion, death occu	irred at the time, da	ate and place,	and due to	o the cause(s)	
29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	29	d. Date signe	d (Month.	Day, Year)	
X a B	0001		_	33255					
Tubo	ver			JJ2JJ		ECEMBER	. / 5	2010	
30 Name and address of person w	the completed cause of death (Ite)	m 23a) (Type.	EURU						

State Registrar 31. Date filed (Month, Day, Year) DEC 1 0 201

34

KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Irene Marie Bohac December 8°, 2010° 3 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Columbia Howard Social Security Number 7. Age (In vrs. last birthday Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Ohio 1 □ M 2**X** F Months Hours April Daz 5 1914 272-03-7808 96 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Md. 1 Yes 2X No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9451 Brett 21045 "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **N**O Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify. Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates er than "natur the Medical E Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Licensed Practical Nurse Medical permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gaspar Rusnak Mary Kurimskij 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph W. Bohac /son 9451 Brett Lane Columbia, Md. 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Donation 5 C Other (Specify) 12/9/2010 Hanover Md Crematory Inc. . Signature of Funeral Service Lig 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between ereberal Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami ending physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 2 XNo should be detached 9 Unknown 9 I Inknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ■Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Definition of the value of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi VYD 2010

State Registrar

10

30. Name and address

103

erson who completed cause of death (Item 23a) (Type, Print)

6334

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 Year 10 9:15 a M Lucy M. Blyskal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Rising Sun Calvert Manor Care Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F Country) Delaware 93 Months Days Hours (Month, Day 9 127 221-07-5773 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 X No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21911 1881 Telegraph Road 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married al Hygiene. d other than "natural", o event, the Medical Exan 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 08 College (1-4 or 5+) Cafeteria Worker traumatic event, Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumast 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Martha Marszelewska Felix Cichocki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 N. Maryland Ave Wilmington, DE 19804 Marianne Fedora - daughter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/17/10 Wilmington, DE Cathedral Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 111 S. Queen Street R. T. Foard Funeral Home Rising Sun, MD 21911 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Alzheimeris mentia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pemphigoid 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe or Attending Physician: The 1 ☐ Yes 2 ☐ No certificate Yes 2 N ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 **M**No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital of 24 hours a Funeral D Medical 29a. Certifier Kicertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00028324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. LATTIN M.D 101 COLONIAL 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mary		artment of H			giene 2 (10	40628
		,	Decedent's Name (First, Middle, Last)				ath		3. Time of Death	
	Physicia Medio		Robert L. Brock			<u> </u>	Month I 2	T1	Year	1:42 a M
	Examin	er	4a. Facility Name (if not institution, give street and number) 2745 Blue Ball Road		Elkton	Location of Death , Marylar		4c. County of Death Cecil		
	Funeral Director		218-38-2577 1 [™] M 2□F	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl		9. Birthp Coun	place (State or Foreign try) MD
	nd how at	۲	Usual Residence of Decedent 10a, State 10b. County 10c	:. City, Town or Lo	cation				1	0d. Inside City Limits
	larylar 3a-f sl iified	Director		Elkton						1 🗆 Yes 2 🗖 No
	the N a or 28	Dir	10e. Street and Number		10f. Zip Code			10g. Citizen o	f What Cour	itry?
	h with	Funeral	2745 Blue Ball Road		21921			USA	`	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Der artiment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever i Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, fy: Wh	
2-0	hour "natur dical	plete	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa kind of work done o		kina	16b. Kind of	Business Inc	dustry
7	thin 72 ine. than	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	O NOT use retired)	anny most or wor	ung	Stato	of M	aryland
Q 25	ed wit Hygie other ent, th	Be C	12 17. Father's Name (First, Middle, Last)	пат	ntenance	18. Mother's Nan	ne (First, Middle,			aryland
/lan	d be fill Mental arked o	2	Edward Brock				L. Broo			
Man	d 2 shoule alth and N 1 27 is ma er trauma	ĺ	19a. Informant's Name/Relationship (Type, Print) Helen M. Brock/wife		ng Address (Street a					Code)
Baltimore, Maryland 21215-0036	Page 1 an nent of He int: If item ry or othe		1 Rurial 2 X Cremation 3 Removel from State	Db. Place of Dispo cemetery, crer R . T . Fo	sition (Name of matory or other plac ard Funer		7°1°3/10 P.A.	20c. Location	n - City or To	
Balti	per mit. I Der artri Importa any inju		21. Signature of Funeral Service Licensee		Name and Addres		Home,P.A	111 8	S. Que	en Street
			23a. Part . Enter the disea , or complications that cauled the shock, or heart failure. List only one called on each line.	death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory an			Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	of de	mg					Onset and Death Whans
-A	Examiner		Due to (or as a con	sequarce of):	o					
-	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	sequence of):						
	icate be executed iphysician and is the burial-transit	I Exa	that initiated events cresulting in death) Last C. Due to (or as a con	sequence of):						
9	ate be physici the bu	dical	d							
687	ertifica iding p	√Me	IF FEMALE: 23c. If yes, outcome of pr	egnancy				224 5	ate of delive	201
Box .	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit	Physician/Me	230. was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live Birth 2 4 Pregnant at time		Ectopic pregnanc Other (specify)	y		I .	fonth	Day Year
<u>0</u>	s that t gned b se deta		Part II. Other significant conditions contributing to death but no	t resulting in the u	ınderlying cause giv	en in Part I.		/		e cause of death?
rds,	equire een sk	eted	-				1 9			pably 4 🗆 Unknown
Seco	he law n tte has b age 2 sh	Completed by					24a. Was autor perfo 1 Yes	osv	Were autor prior to condeath? 1 Yes	esy findings available mpletion of cause of
ē	sian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?			ace of Death (Chec		Z E NO	1 🗆 103	2 110
<u> </u>	Physic this co al dire	욘	. T F. IHOSDITAL:	2 ER/Outpatier		4 ☐ Nursing H	ome 5 Resid)
0 0	nding l tth. ! After e funer	cate	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation		work		28d. Describe h	ow injury occu	rredi	
Division of Vital Records,	al or Attending P s after death. Il Director: After t ed in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - 4 building, etc. (Sp		eet, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
Ω	Hospital 24 hours Funeral eted filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my k	nation and/or invest	tigation, in my opinio	on, death occurred a	at the time, date a	nd place, and d	ue to the cal	use(s) and manner stated.
	To the within To the Comple	_	29b. Signature and title of entifier		29c License	number		20d Date sign	ed (Month, I	Day, Year)
			/ Jachder 3 MD		Da	23322		12.	13.20	10
•			30. Name and address of person who completed cause of death S - S Sa ohdev MD 126 31. Date filed (Month, Day, Year) 32. Registrar's S	(Item 23a) (Type, F	High ST,	Elhto	n Mo	21921		
	Stat Registra		31. Date filed (Month, Day, Year) DEC 14 2010 32. Registrar's S	ignature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Batton 5:43 PM Ellwood Eugene December 1 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Washington **Examiner** Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Decth, Day, 1 **X**M 2 □ F Hours Year) 935 **Virra**inia 218-32-4674 75 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hancock 1 Yes 2 KNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21750 11724 Ziegler Road SE U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3√√ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel worker Steel 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Austin Charles Batton Hattie Virginia Eugene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6238 Windy Ridge Road, Baldwin, MD 21013 Melinda Holly Joyce 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Hagerstown Crematory 12/21/2010 Hagerstown, MD ignal u e of Funeral Service Licensee 22 Name and Address of Facility Helsley-Johnson Funeral Home, Inc. MQ9522 95 Union St., Berkeley Springs, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death RESPIRATORY Physician PAILURI ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): PANCYTOPENIA the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): HYPO IMMUNOGLOBUNENIA resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Yes 2 No Unknown 9 Unknown ģ been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2√☐ No 2 No Yes After this certifical funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury ✓ Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MOHAMMED A212 66892

Registrar

State

11116

Campus Rd

21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammed

31. Date filed (Month, Day, Year)

AZIZMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State State Registrar	ate of Maryland /		artment of H		nd M	-	jiene Neg. No.20	10	40630
			Decedent's Name (First, Middle, Last)						2. Date of Dear	th	V	3. Time of Death
	Physicia Medio		Bernadette Mar	ie Jeanne	Ва	udry			Nov. 2	9 , 2 01 () Year	12:26a™
	Examin		4a. Facility Name (if not institution, give street a			4b. City, Town, or				4c. Count	,	
. 50	/ 		1429 Winding Waye			Silve					itgon	
	Funeral		5. Social Security Number 6. Sex 1 1 1 M 2	7. Age (In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. Min.	8. Date of Birth 4 (1) 2th, Day		g. Birthp Coun Fra	place (State or Foreign
	Director		Usual Residence of Decedent	30	115.				4/21/1	900	rra.	iice
	and show at	ŏ	10a. State 10b. County	10c. City, To							1	0d. Inside City Limits
	Aaryla 8a-f tified	Director	Md Montgomer	y Sil	ver	Spring						1 🗆 Yes 2 🛂 No
	the l	Ö	10e. Street and Number			10f. Zip Code				10g. Citizen of		itry?
	n with	Funeral	1429 Winding Waye	Lane		209				Fra	ance	
	death item nern		Ar Ar	as Decedent Ever in U.S. med Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin n, Mexican, F	n? (Spec Puerto R	ify Yes or No- ican, etc.)		ce - Americ	
36	after II", or xami	d by	o D Midawad A D Disawad If'	☐ Yes 2 🔼 No Yes, Give		☐ Yes 2 No				Specify	TATI	ite
8	atura cal E	Completed	15. Decedent's Education	n Infantes.	Sa. Deced	ent's Usual Occupa	ition		T	16b. Kind of E	Rusiness Ind	duetry
75	יי 72 ל ה. an "m Medi	mp	(Specify only highest grade com Elementary/Seconday (0-12) Co	npleted)	(Give k	rind of work done du D NOT use retired)	uring most o	f workin	g	TOD. TAILS OF E	3 4 5111655 111	30017
7	withir giene giene ier th		Elementally/Seconday (0-12)	blege (1-4 or 5+) 5 +	НС	memaker				Owr	1 Hom	ie
p	filed al Hy d oth	To Be	17. Father's Name (First, Middle, Last) Pierre Baudry				18. Mother's Δ n r	s Name	(First, Middle, M Charpe	Maiden Surnam	ne)	
yla	lld be Ment narke natic	ř										00000
Nar	shou n and 7 is n		19a. Informant's Name/Relationship (Type, Prin Anthony Thomas Ma			g Address (Street a						
e,	and 2 Health em 2 ther 1		20a. Method of Disposition			Windin Sition (Name of	y way		ate T	20c. Location		
ō	age 1 ant of t: If it		1 Burial 2 XCremation 3 Remov	ceme	terv. crem	eake Cre	m 12			Belts	•	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) 21. Signatur Juneral Service Lice e	a circ.		-						
B	permi Depar Impo any ir once.		VIII RATION	Kr	92	41 Colu	mbia	Bİ,	d.Sil	ver Sp	ring	,P.A. ,Md20910
П			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus	is that caused the death. Do	o not ente	r the mode of dying	, such as ca	ırdiac or	respiratory arre	est,		Approximate Interval Between
~	Ph sician/		Immediate Cause (Final			4 Tumo						Onset and Death
	Medical Examiner		resulting in death)	Respiratory Due to (or as a consequence	e of):	TIME						1
	LAdillilei	<u>,</u>		Metastatic		g cance	r				_	1yr
	g ts	Examiner	Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or linjury	Due to for as a consequence	e off:							
	and	Exal	that initiated events C. —	Due to (or as a consequence	e of):							
0	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		d									
P.O. Box 68760	ficate g phy as the	by Physician/Medical	_ = = =									
8	endin use	an/i	ZSD. Was decedent pregnant	yes, outcome of pregnancy □ Live Birth 2 □ Fetal dea	ath 3	Ectopic pregnancy	/				ate of delive	*
80 0	death ne att ed for	sici	1 Vos 2 ANO	☐ Pregnant at time of death☐ Unknown		Other (specify)	<u>'</u>			M	onth	Day Year
o	at the	Phy	Part II. Other significant conditions contribut	ing to death but not resultin	a in the u	nderlying cause give	en in Part I		23a Did tol	hacco lieo con	tribute to th	ne cause of death?
α, σ.	es tha signed I be d		. at the state of	g	g 11. 11.0 u.	racinying cause give						pably 4 Unknown
ğ	requii been should	Completed							24a. Was a	n 24h	Were auto	osy findings available
မင္ပင	Physician: The law this certificate has all director, page 2 s	dm							autops	sy	prior to co death?	mpletion of cause of
œ E	n: The ficate or, pay		25. Was case referred to medical			26 Pla	ice of Death	(Chook	1 Ves	2 🔼 No	1 Yes	2 🗆 No
/ita	s certi	To Be	examiner? 1 Yes 2 No Hospita	al: 1 Inpatient 2 ER/0	Outpation	Othe		the ball	ne 5 🔀 Reside	2200 6 T Oth	or (Specific	
of	g Phy er this ieral c				. Time of injury	28c. Injury	at		8d. Describe ho			/
on	ath. pr: Aft	fical	1 Natural 5 Pending 2 Accident Investigation	(World), Day, Year)	injury	M 1 □	r Yes 2□N	lo				
Division of Vital Records,	or Atte	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		2	8f. Location (St City or Town		oer or Rural	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		OG- OUNTER A Thomas . The same .	To the heat of my	a d	acured -t-t-	Jaka 1 1					
	Hos 24 hc Fune	Medical	29a. Certifier (Check 2 Medical Examiner: Only one) 3 Certifying Nurse Prac	the basis of examination and	d/or invest	igation, in my opinior	n, death occu	urred at t	he time, date ar	nd place, and du	ue to the car	use(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	and the state of the Mile	Jugo, C	29c. License		piace		29d. Date signe	ed (Month, i	Day, Year)
	1D		> Ventimon	~		MD03	7655			Dec.	2,20	10
	, , -		30. Name and address of person who complet Irina Veytsma		Mic	rint) higan A	ve.NW	l Wa	shingt	con,D.	c.	
	Stat Registra		31. Date filed (Month, Day, Year) OEC 07 2010	32 Registrar's Signature	La	al.						
	. region (APA A . MAIA		1	Table 4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 02. 2010 Randa11 Bell, Sr. 1:10 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** #110 Glen Burnie 211 Westport Bay Drive Anne Arundel Social Security Number 8. Date of Birth (Month, Pay, Year) Jan 19 1 Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 □ F Months Days 52 1958 Washington, DC 218-76-4435 Director Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Glen Eurnie Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 211 Westport Bay Drive #110 21061 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 2 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Roofing should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sylvia Clark John E. Bell and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) ling Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Westport Bay Drive 101, Glen Burnie, MD 21061 Kathleen M. Bell - Wife Department of Health Important: If item 27 any injury or other tr Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Wash. Crem. 12/10/2010 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of). resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death signed by the at the detached for 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No certificate 1 🗌 Yes Yes 2 25. Was case referred to medical Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ဍ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending hours after death. Ineral Director: Al 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For State Registrar			Marylan		artment of F tificate of L		Re	ene g. No.2 () ()	1.0632	
an/ ical	1. Decedent's Name (F	Brooks	_	<u>.</u>				2. Date of Death Month December		3. Time of Death 12:15p M	
ner	4a. Facility Name (if no Anne Aru 5. Social Security Num	undel M	ledical Cer		ast birthday)	Annapo1	If Under 24 Hrs.	8. Date of Birth	4c. County of Dea	unde1 thplace (State or Foreign	
	219-32-680 Usual Residence of De	06 ecedent	1 □ M 2 🔀 F	76	Yrs.	Months Days	Hours Min.		n Burnie,MD		
To Be Completed by Funeral Director	MD A	Ob. County Anne Ar	undel		y, Town or Lo	3				10d. Inside City Limits 1 ☐ Yes ※XXNo	
Funeral L	10e. Street and Number		Lane	A Front in III S	110 1	10f. Zip Code 2105 Was Decedent of H	g. Citizen of What G				
ed by Fu	11. Marital Status1 ☐ Never Married3 ☐ Widowed 4 ☐		Armed Forces	s? X No X	1		an, Mexican, Puerto		Black, Whit	te, etc.	
Completed	(Specify Elementary/Second		grade completed) College (1-4 c	r 5+)	(Give I life. D	O NOT use retired)	ation during most of worl	king	6b. Kind of Business	,	
اما	12 17. Father's Name (Firs		,		Te	eacher		ne (First, Middle, Ma	iden Sumame)	el CO. Scho	
	Francis 19a. Informant's Name Catherine	e/Relationship	(Type, Print)	r			and Number or Rui	ine Wigl ra/Route Number, C mbrills,	ity or Town, State, Z	ip Code)	
	20a. Method of Dispos 1 Burial 2 2 4 Donation 5	Cremation 3	☐ Removal from Sta	ate At I	Place of Dispo emetery, cren antic	sition (Name of natory or other plac Cremator	e) 12/0		0c. Location - City o 1en Burni		
	21. Signature of Fyrer	ral Service Lice	free/		22 Ha	Name and Addreservardesty F	ss of Facility 'uneral H	ome P.A.G	51 Annapo ambrills,	lis Road MD 21054	
	23a. Part 1. Enter the shock, or heart f Immediate Cause (Fir disease or condition resulting in death)	ailure. List only							·	Approximate Interval Between Onset and Death	
al Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Interval Between Cause (Final disease or conditions) Last Pulmonary Edema Deadous 2 does not consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
Physician/Medic	IF FEMALE: 23b. Was decedent pr in the past 12 mg 1 Yes 2 1 9 Unknown	nths?	23c. If yes, outcon 1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	h 2 🗌 Feta t at time of c	al death 3	Ectopic pregnand Other (specify)	ру		23d. Date of do	elivery Day Year	
þ	Part II. Other significa		contributing to death			inderlying cause gi	ven in Part I.			o the cause of death? Probably 4 Unknown	
Completed								24a. Was an autopsy perform 1 \square Yes 2,	ed? prior to death?	utopsy findings available completion of cause of es 2 No	
Be	25. Was case referred examiner? 1 Yes 2		Hospital:			Oth	er:		- U au - a	***	
Certificate: To	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigat	28a. Date of in (Month, I		28b. Time of injury	28c. Injur	y at Nursing H	28d. Describe how	ce 6 Other (Spe	ciry)	
	4 Homicide	6 Could no determine	ed 28e. Place of building,	etc. (Specify	·) 	eet, factory, office		City or Town,			
Medical	(Check 2 L	Medical Exa Certifying N	hysician: To the best miner: On the basis o urse Practioner: To t	of examination	n and/or inves	tigation, in my opini death occurred at th	on, death occurred and pla	at the time, date and ace, and due to the c	place, and due to the ause(s) and manner a	s stated.	
	290. Signature and titl	e or centrier	. 0			29c. Licens			d. Date signed (Mon	, 3 2010 S Maryla	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09, 2010 Physician/ ISBAC OCTOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICAL CENTER BALTIMORE SAINT JOSEPH TOWSON . Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under Year **Funeral** 1 XM 2 □ F Days NONE Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 ☐ No BALTIMORE MARYLAND ò 10e. Street and Number 10g. Citizen of What Country? Funeral tems 23a 1). S. A. ROAC Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mentai Hygiene. Important I fitem 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examit Completed by 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ BROOKS DARIUS CASHMERE 19a. Informant's Name/Relationship (Type, Print)

DARIUS BROOKS

+ CAShmERE FORS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARENT Kitmore 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy RELEEMEN CEMPTH 22, Name and Address of Facility
St. Joseph Medical Conten rvice Lige DLIVE Towson, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final RESPIRATORY FAILURE €nysician/ HOUR ITMIN. disease or condition resulting in death) **Medical** Examiner XTREME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Director completed filled in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. fertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title D44809

State Registrar 7601 OSLER DRIVE TOWSON MARYLAND 21204

ompleted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 10,2010 JUNIOR S. CASTEEL December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner Garrett County Memorial Hospital Oakland Garrett If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Director 233-46-9531 79 11/28/1931 Usual Residence of Decedent with the Maryland 10c. City, Town or Location or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantine Injury to confired at once. Director WV Monongalia Morgantown 10g. Citizen of What Country? 10e. Street and Number 11 Rock Forge Lane 26508 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coal miner 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph S. Casteel Viola Deavers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jody Biedron Rock Forge Lane, Morgantown, WV 26508 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Hill Cemetery 12/15/2010 Morgantown, WV 22. Name and Address of Facility ature of Fur eral Service License Fred L. ed L. Jenkins Funeral Home South High Street, Morgantown,WV 26501 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only on Immediate Cause (Final **Physician** 2 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours a

To the Funeral C

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edical Examiner														
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 ∐No 9 ∐Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year											
Completed by Ph														
Be (25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)											
ဝ	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify)											
Certification:	27. Manner of Death 1 M Natural 5 □ Pending 2 □ Accident investigation	28a. Dàte of Injury (Month, Day, Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	escribe how injury occurred											
Certific	3 ☐ Suicide 6 ☐ Could not to determined	1 286. Place of injury - At nome, farm, street, factory, office 1 28f, Loc	cation (Street and Number or Rural Route Number, y or Town, State)											
edical (hysician: To the best of my knowledge, death occurred at the time, date and place, and duminer: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.												
Me	29b. Signature and title of certifier	29c. License number H 006 170 5	29d. Date signed (Month, Day, Year)											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

Approximate Interval Between Oaset and Death

1 □Yes 2 □No

WV

DHMH 17 Rev 1/2001

State Registrar , 311 N Fourth St Suite 1, Oakland MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

Panter

Date filed (Month, Day, Year)
DEC 1 4 2010

Richard

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

1		For State Registrar	State of	Marylan			of Health a of Death	and M	lental Hy	giene Reg. No.	20	0	L0635
		1. Decedent's Name (First, Middle, La.	st)						2. Date of De	eath Day	Ye	3.	Time of Death
Physicia /Medic		Gloria E. Cr	aven						Novem	ber	29.	2010	12:54P
Examin		4a. Facility Name (If not institution, giv	e street and numb	per)		4b. City, Tov	vn, or Location o	of Death		4c. 0	County of I	Death	
		Fort Washingto				Fort	Washi Gear If Under	ngt	8. Date of Bir	Pr	ince	Ge G	State or Foreign
Funeral Director		5. Social Security Number 6. S	ex □ M 2√2 F /	. Age (In yrs.	Vre	Months D		Min.	(Month, Da	ay, rear)		Country)	
		577-66-3248 Usual Residence of Decedent			3 118.				Oct.24	192	± /V	Wash.	<u> </u>
how	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							nside City Limits
Ba-f s	Director	MD PG		F	ort W	ashin							Yes 2□No
or 2		10e. Street and Number				10f. Zip Co	ode			10g. Citiz	en of Wha	at Country?	
s 23a	Funeral	10800 Indian H	ead Hig		#B20		0744	igin? (Sp	noify Ve o or No	Unit	ed S	State American Ir	S
item	F.	11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Force	es?			t of Hispanic Ori Cuban, Mexicar	n, Puerto	Rican, etc.)			White, etc.	raiding
al", or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 ☐	No Specify:				Specify:	Blac	k
natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation			dent's Usual C	Occupation Jone during mos	t of worki	ina	16b. Kir	nd of Busin	ess/Industr	у
ne.	du du	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use r	retired)						
illed within 7.2 frouts after death with the waryants. Hygiene. than "natural", or items 23a or 28a-f show ent, its in After Exactine must be codified.		1 2 17. Father's Name (First, Middle, Last,	1		Pos	tal C		or's Name	e (First, Middle			t Of	fice
ed of	Be												
mark matic	<u>٩</u>	Richard Crave			19b Mailir	na Address (S	treet and Numb		ine al Route Numb			ate. Zip Cod	de)
id 2 s Ilth ar 27 is rtrau		Roderick Young			1221	6 Swee	500wte	Pla	ce	,		,	,
perfitt. Tages I alto 2 should be filed within 72 frouts after beauthwith the wallyfall Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Modical Exaction and included at once.		20a. Method of Disposition		20b. F	Wald Place of Disponentery, crem	ort sition (Name	MD. 20	602 [Date	20c. Lo	cation - Cit	ty or Town,	State
rages nt: If ry or		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification)					Cemete		/10	C1	into	on, M	D
partm porta y inju		21. Signature of Funeral Service Licer	nsee	4			Address of Facili		lges &				
B B E B		Janice	Tawa	ude			ilver 1						
		23a. Partil. Enter the disease, or com shock, or heart failure. List only	one cause on eac	ch line.				Λ (/	arrest,		Inte	proximate erval Between set and Death
hysician		Immediate Cause (Final disease or condition	a At	heros	cleration	Cor	onory 1	fr te	ery L	lisea:	se	On:	set and Death
/Medical xaminer		resulting in death)		r as a conseq			,						
.xammer	<u>_</u>	Sequentially list conditions,	b	r as a conseq	u ana a of):								
nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a conseq	juence on).								
n and al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or	r as a conseq	uence of):								<u> </u>
sicial sicial	cal		d.										
incau ig phy as the	ledi												
endin	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregn		☐ Ectopic pred	nancv			2	23d. Date o		. Van
he att	sicie	in the past 12 months? 1 ☐ Yes 2 ANo		int at time of		Other (spec					Month	n Day	/ Year
d by the	Phy	9 Unknown							220 Did	tobacco	so contribu	uto to the co	ause of death?
signe be d	þ	Part II. Other significant conditions of Hypertensia	0	itri but not res	sulling in the u	nderlying caus	se given in Part	l.		Yes 2			/ 4 ☐ Unknown
neen (Completed		Mellit	<									
has has h	mpl	Diabetes	mellit	V3					24a. Was	onsv	pric	ere autopsy or to comple ath?	findings available etion of cause of
ficate r, pag		05 11/2	T							ormed? 2 No		Yes 2	No
sicia certi irecto) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No	Hospital:	patient 2	ER/Outpatie	ot 3 🗆 DOA	Othory		h <i>(Check only</i> ome 5□ Res		C □ Othor	(Chooifu)	
a riny er this eral d	n: To	27. Manner of Death	28a. Date of	Injury	28b. Time o	T	Injury at Work?	dising ric	28d. Describe			(Specify)	
ath. r: Afte	atio	1 Accident 5 ☐ Pending 2 ☐ Accident investigatio		, Day, Year)	Injury	м	1 ☐ Yes 2 ☐	No					
er deg	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place 0	f Injury - At h	ome, farm, sti	eet, factory, o	ffice		28f. Location	(Street an		or Rural Ro	oute Number,
rs aft al Di	Certification:								,				
To the nospital of Attending Priystcian: The law requires that the death certificate be executed within 24 does the death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	sis of examin	owledge, deat ation and/or ir	h occurred at vestigation, ir	the time, date a n my opinion, de	ind place, ath occur	, and due to the red at the time	e cause(s) e, date and	and manr place, and	ner as state d due to the	ed. e cause(s)
orthin orthin omple	Med	29b. Signature and title of certifier					icense number			29d. Dat	e signed (Month, Day,	; Year)
- > - 0		1/1/1	11/1/	MD		I.	14674			Nove	em ber	7 29	, 2010
		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,								
5			indera,	M.D.	111111	Livin	aston	Rd	, Fort	Was	hino	ton, 1	UD 20744
Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature		J		,)	, /	
Registr		DEC 0 7 2010	ensur »,	1. July									
H 17 Rev 1/2	004												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21:35 PM James Harold Countess 77/53/5070 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Director 219-55-7751 59 or 28a-f shov 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shor permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director MD Prince George's Temple Hills 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3409 Rickey Ave. 20748 AZU 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chauffeur Health & Human Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henrietta Nelson Joseph Parlee Countess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis M. Countess / wife 3409 Rickey Ave., Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem: 12/14/2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Strickland_Funeral 6500 Allentown Rd⋅₁ Camp Springs₁ MD 20748 T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End St 196 Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 05pile Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit phlumo To the Hospital or Attending Physician: The law requires that the death certificate be executed DhL Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Day Year Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 FR/Outpatient 3 IDOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State

only one)

29b. Signature and title of certifier

7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

11120110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ Month 2010 Timothy Clark December James Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 3420 Rickey Avenue Apt 343 Temple Hills If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Yea, Oct 30, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months 189-34-9085 Director Pennsylvania 68 1942 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No Temple Hills Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? ò 10e Street and Number Funeral items 23a United States 20744 3420 Rickey Avenue Apt 343 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: "natural", 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Brick Layer 12 Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Cooper Ralph Clark Dorothy Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 Rickey Avenue Apt 126 Temple Hills, MD 20748 Lois Street/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🔀 Cremation 3 🗀 Removal from State Journey Crematory 12/13/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa re of Funeral Service L Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 thomas uanta R M00957 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ 5 months Pancreatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 유 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier D64234 December 8, 2010

State

M.D. 8926 Woodyard Road, Suite 101 Clinton, Maryland 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

E BAAAA

DeMonaco,

Nicholas A.

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Christiansen 2010 December 6. 15 Medical <u>Joanne</u> W. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 9117 Hendry Terrace Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Feb 4, 1938 1 M 2 XF Months Pennsylvania **Director** 72 186-30-9639 Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 28a-f shov 10a, State 10b. County within 72 hours after death with the Maryland 10c. City Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland Frederick Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9117 Hendry Terrace 21704 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 5 Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: "natural", 3 XWidowed 4 Divorced White 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Municipal Government event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o မ Robert Woods Henry Sarah Catherine Nigro traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 9117 Hendry Terrace Frederick, Maryland 21704 Laura Christiansen-Willett, other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Final Journey Crematory 12/10/2010 Woodbine, Maryland 21. Sign re of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 thomas M00957 Beverly L. Heckrotte, P.A. Clarksville, 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonur Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequance of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After death. -transit Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 🗌 Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

5

Registrar DHMH 17 Rev 7/2009

State

(Check

only one) 29b. Signature and title of certifie

Gerul A DelGri

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

CSCA-A

Registrar's Signature

63

Thomas

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Johnson De Frederick, MD 21702

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

			For State O	i Maryland / Depa	tificate of E			Reg. No.	40639
	Dhysisia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Dea	ıth	3. Time of Death	
Physicia Medic		al	ADELAIDE CASSI 4a. Facility Name (if not institution, give street and num		45 Cit. T	Ltion of Dooth	DECEMBE		
Examir		er	UNION HOSPITAL	4b. City, Town, or Location of Death ELKTON			4c. County of Death CECIL		
П	Funeral Director			urity Number 6. Sex 7. Age (In yrs. last birthday)			8. Date of Birth 8/I4/I	h 9,1	Birthplace (State or Foreign Country)
	. Page 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at		Usual Residence of Decedent						
		Director	MD CECIL 10c. City, Town or Location ELKTON						10d. Inside City Limits 1 X Yes 2 □ No
			10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
		Funeral	1 PRICE DRIVE		21921			UNITED STA	
900		To Be Completed by Fi	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Dece Armed For 1 ★ Yes, Giv Year or Da	2 □ No e	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛣 No		ecity Yes or No- Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. WHITE
21215-0036			15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-	-4 or 5+) (Give life. D	dent's Usual Occup kind of work done o O NOT use retired)		king	16b. Kind of Busine	·
d 22			17. Father's Name (First, Middle, Last)	HOME	MAKER 	18. Mother's Nan	ne (First, Middle, I	OWN HOME Maiden Surname)	
ylan			DIEDRICH DIECKMANN		ELIZABETH AHEARN				
Maryland			19a. Informant's Name/Relationship (Type, Print) SUSAN MURPHY/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 176 DANFORD DR ELKTON, MD 21921					Zip Code)	
Baltimore,			20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 🕅 Removal from	20b. Place of Dispo	sition (Name of	- 1	Date	20c. Location - City	or Town, State
Ħ.			4 Donation 5 Other (Specific VETERANS CEMETERY 12/10/2010 WOODSTOWN,					I, NJ	
Ba	permit Depar Impor any in once.		21. Signature of Funeral Struce Leep ee 22. Name and Address of Facility SPICER-MULLIKIN FH 1000 N DUPONT PKY NEW CASTLE, DE 19720						
	Medicate be executed Examine physician and ruse as the burial-transit	iner	25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one duse on each line. Approximate Interval Between Onset and Death disease or condition						
			Asserting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last PNE UMONIA Due to (or as a consequence of): Luc to (or as a consequence of): Cononing Alexy Difficult Due to (or as a consequence of):						
1			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	י -		ince.			
		Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	leng Dis	leng Disson				
00			d						
x 68760		d by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, out 1 ☐ Live	Ectopic pregnanc	cy .		23d. Date of delivery Month Day Year		
P.O. Box 68	he deat y the at ched fo		1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other 9 ☐ Unknown			Other (specify)		_ Worth Day real	
s, P.0	ries that the signed by detail		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
ord	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a er death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled is by the funeral director, page 2 should be detached for use as the burial-transit	plete							autopsy findings available to completion of cause of
Rec		Completed					perfor	rmed? death	
/ital		To Be	25. Was case referred to medical examiner? 1						
of			27. Manner of Death 28a. Date	28c. Injury at work?		28d. Describe how injury occurred			
Division of Vital Records,		al Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			Yes 2 □ No		(Street and Number or Rural Route Number,	
			4 Homicide determined determined building, etc. (Specify)						
		ledical	29a. Certifier (Check only one) 1						
		Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Monti					onth, Day, Year)	
	•7		P.V. Nonge N. MD DOU 65733 12/06/13					٥	
30. Name and address of person who completed cause of death (Item 23a) (NARAYANA RAO V-PULA, 126 A						H Meet	FLKT	0 N MB 2	1921
	Stat Registra		31. Date filed (Month, Day, Year) 32. R	A 116 A Gegistrar's Signature	/				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wayne Currence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS-RMC Allegany Cumberland Birthplace (State or Foreign Country)
 WV 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 1 QM 2 DF Hours ′Mav°16°. Director 232-68-9123 66 Usual Residence of Deceden 28a-f show death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director WV Wiley Ford Mineral 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? Funeral items 23a Rt. 1 Box 18 26767 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Vietn Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Vietnam Specify 3 Widowed 4 Divorced white Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) machinist Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alma (Oxley) Currence William L. Currence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 1 Box 18 Wiley Ford WV 26767 Janet Currence wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 ☐ **K**emation 3 ☐ Removal from State 12/16/2010 MD Cresaptown Donation 5 C Other (Specify) Signature of Funeral 22. Name and Address of Funeral Home, PA ervice Licensee 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between shork, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 Yes 2 No 2 No Yes completed filler in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 🗌 Pending work?
1 \(\sum \) Yes 2 \(\sum \) No 24 hours after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse-Pfactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Harold Cox Day $_{\mathbf{P}}^{\mathsf{M}}$ 2010 12:05 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 146 Brightwater Drive Annapolis Anne Arundel . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 XX 2 1 225-90-2831 53 Director 15, 1956 Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 No 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 146 Brightwater Drive 21401 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 9 Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates White should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harold D. Cox Doris Oberlander permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheri Neri/sister 4510 Sonata Court Fairfax, Virginia 22032 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory 12/8/2010 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home JULY 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause an each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year ned by the a e detached f 9 Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe or Attending Physician: The certificate Yes 2 No 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? ما Other: 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury nours after death.

neral Director; After the filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completed fil 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Fractioner To the best of my knowledge, death on med at the time, dath and place, and due to the causists and marker as stated 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONES 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04 Month 201°0 1AM Richard Thomas Corradini Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 Months Days Hours Min 83 1 IMP 1 16 9 94 99 277 Michigan **Director** 375<u>-26-1869</u> or 28a-f show 10a. State 10b, County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21403 USA 1200 Chrisland Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Xs, Give Korea Year or Dates. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Municipal Purchasing Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Corradini Angelo Ivah Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrel Kent Chrisland Court Annapolis, MD 21403 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Robinson Cemetery 12/08/2010 Bloomingdale TWP,MI 22. Name and Address of Facility
Hardesty Funeral Home P.A. Annapolis, MD 21401 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the unlease, or complications that caused the death. Do not enter the mode of dying, such as cardioc or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 1100 မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director; After ompleted filled in by the fun 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Fractioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the reuse(s) and manner stated. 3 29b. Signature and fit doress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:30 Josie B. AΜ Dyson 2010 Medical December 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Crescent Cities Center Riverdale Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You Sept. 26 **Funeral** 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M 2 X F Director 577-60-1102 83 Washington, DC Usual Residence of Decedent or 28a-f show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 No Md Prince George's Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3623 Edwards Street 20774 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2X No Specify. Black Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Statistician DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Perry Lightsey Alice Cleckley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Ronald Dyson / Son 1924 Carters Groove Dr. Silver Spring, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 12/13/10 Brentwood, Md Signature of Funeral S ensee 22. Name and Address of Facility Fort Lincoln Funeral Home rela lances 3401 Bladensburg Rd Brentwood, Md 20722 23a. Part 1. Enter the dis-as-, or complications that caused shock, or heart fail-re. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Weeks Immediate Cause (Fina Priysician/ Resistant Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dementia Years Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for uses as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify, 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -5-1 D17874 12/8/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sankaran Nayar, M.D. 38th Cottage City, Md 20722 Ave

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DAVIS Month // Physician/ Year GEORSSIAH 22:13 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death SOUTHEREN MARYLAND HOSPITAL CLINTON Prince GEDEGES Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XF Country) 219-87-4845 Director Usual Residence of Decedent 28a-f show 10a. State 72 hours after death with the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director CLINTOR MD 1 Yes 2 No ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20135 items 23a 5809 115A JACKIES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married 2 X No Completed by Baltimore, Maryland 21215-0036 Ves 1 ☐ Yes 2 XNo Specify If Yes, Give Year or Dates Specify: BLACK 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) NIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ¿ ပ HARESA DAVIS LIEDRGE permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARESSA DAVIS CLINTON 5809 JACKIES WAY UD HOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Bowman, SC 12-6-2010 4 ☐ Donation 5 ☐ Other (Specify) BAPT CHURCHCEM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 814 UASHUR ST NW WASH OC 2001/ BIANCHI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death r.Som-Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 5e 0815 Sequentially list conditions, if any, leading to immediate cause. East Underlying Examine Due to (or as a consequence of) Rig 1,300 preymon, 1 UPNER -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician Physician/Medical P.O. Box 68760 the as for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death
Unknown signed by the a 1 ☐ Yes ∠ y Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an cate has I page 2 s autopsy performe After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 🗆 Yes မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29/112 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13 2010 Louis Joe Diaz 2:25 P December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland Allegany Allegany Health Nursing Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Feb. 4. Year 915 95 1**XX**M 2 □ F 216-07-8107 Marvland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany Luke MD 1 🛣 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21540 343 Nevison Ave. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Decedent Ever in U.S.

Armed Forces?

1 ▼ Yes 2 □ No WW 2

If Yes, Give

Year or Dates. Black White etc 1 Never Married 2 Married þ Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Manufacturer Shift Engineer unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alvarez Alfredo Diaz Josephine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code)
22115 Westernport Road, Westernport, Maryland 21562 Michael Diaz/ son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Philos Cemetery 1 X Burial 2 Cremation 3 Removal from State 12/17/2010 Westernport Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Unknown 9 Unknown P.O. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a, Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 1 Natural 5 Pending Division 1 ☐ Yes 2 🕡 🖊o Accident Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Deciral Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State

DHMH 17 Rev 7/2009

15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Lori A. Dustin 5 Dec. 2:18 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 820 Windsor Rd. Arnold Anne Arundel If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. Oct. 29 Washington, DC Director 218-96-1302 46 Ľ964 Usual Residence of Decedent ural", or items 23a or 28a-f show I Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1110 Fidler Lane #925 20904 U.S.A. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. 1 X Never Married 2 ☐ Married Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) <u>Underwriting</u> State Farm Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ရ Edward L. Dustin Patricia A. Spraitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Dustin (Daughter) 7879 Tall Pines Ct. #D Glen Burnie, MD 21061 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery: 12/9/2010 Brentwood, MD 22. Name and Address of Facility Rendon/Hale Funeral Home Menu 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Liver Failure Medical resulting in death) **Examiner** Hepatitus C Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 3 in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 24a. Was an performed? Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Relative's 1 ☐ Yes 2 🛣 No Other: P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Sp 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. injury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 12/7/2010 D52883

State Registrar 1111 Spring Street #G-1 Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

Oliver Bennett

DEC 0 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 2010 1:15 PM Dec. 6, James E. Dougherty /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cîty, Town, or Location of Death 4c. County of Death Examiner Prince Georges 7126 East Cedar Street Landover If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F South Carolina Director 249-56-8459 72 Sept. 6, 1938 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 🛛 No Directo MD Landover Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 7126 East Cedar Street 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: 3 Widowed 4 Divorced Black er than "natura , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hyglene, tem 27 is marked other thar Auto Mechanic Automotive Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Dougherty Maggie Byrd ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Mary Dougherty - wife 7126 East Cedar St., Landover, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 12/13/2010 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral J. K. Johnson Funeral Home P.A. 6503 Old Branch Ave. Temple Hills, MD 20748 23a. Par 1/Enter the disease, or comp sh ox, or heart failure. List only Approximate Interval Between Onset and Death fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immedi Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) slcian and burlal-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation s after des. ral Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar 29b. Signature and title of certifier

31. Date filed (Month.

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3010 Harriet DIETERICH Joanna 0505 AM Decembe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 214-28-5565 Months Hours Sept. 23,1931 Maryland **Director** 79 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important, If final 71 is marked other than "nature?" ----any injury or other treatment. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2250 Beverly Drive 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 K No Black, White, etc. ģ 1 Never Married 2 Married white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elmer Kune Margie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15814 Shinhan Road, Hagerstown, Maryland 21740 C. Eugene Creek - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Salem Reformed Church December 14,2010 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate val Between Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting jn the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/ No 욘 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4-HCA State 29a C Hiffer (heck

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

DEC

gt the firm

29d. Date signed (Month, Day, Year) Dec 10th 2010

E Culitan St HAGMDZA

Certifying Nurse Practioner: To the best of my knowledge, death unsure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Henri J. Declaron December 2010 4:20 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Manor Care Potomac . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex Funeral 1 🛛 M 2 🗆 F Months Days Hours Min. July 30 **1**919 Director 578-72-3253 91 France Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No D.C. Washington, D.C 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4915 Western Avenue, NW 20016 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 K Married ☐ Yes 2 🙀 No Yes, Give within 72 hours after 1 ☐ Yes 2 ☐MNo Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates other than "natur 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Butcher Hotel/Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve Mental ည Gaston Declaron Marie Giboux should I permit. Page 1 and 2 shoul Department of Health and Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Declaron/wife 4915 Western Avenue, NW Washington, DC 20016 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o once. 1 Burial 2 K Cremation 3 Removal from State Donation 5 Other (Specify) Journey Crematory 12/14/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 uanta R4homas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Arrhythmia Medical resulting in death) Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy 5 Other (specify) in the past 12 months? Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Debility 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Status Post laryngectomy greater than 10 years ago for autopsy performed' Cancer 2 XNo 1 ☐ Yes 2 ☐ No Yes Be

Box 68760 Records, After this certificate ! Hospital or Attending Physician: 724 hours after death. Funeral Director: After this certifica Division of Vital completed filled in by

2

Certificate:

Medical

Susan J.

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar

29c. License number

D35579

8218 Wisconsin Avenue #305 Bethesda, Maryland 20814

29d. Date signed (Month. Day. Year)

December 9, 2010

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Grean

Miller, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DECEMBER 2010 05:25 PM ULYSSES GRANT DEMOND III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL 102 MILL ROAD NORTH EAST 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign NOWITH EAST MARYLAND 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 XM 2 □ F Months Hours Min. Director 87 180-16-8213 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 □ No NORTH EAST MARYLAND CECIL 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral UNITED STATES 102 MILL ROAD or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc Completed by 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give 1 X Yes 2 No If Yes, Give US ARMY Year or Dates. 1943-46 Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INDUSTRIAL SALESMAN INDUSTRIAL BELTING is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ MABLE HINES ULYSSES GRANT DEMOND. JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 102 MILL ROAD, NORTH EAST, MARYLAND21901 LUCIA DEMOND / SPOUSE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State DECEMBER NORTHETER AT STATE OF CHARLES TO THE CHARLES TO THE TERY 1 🖰 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11, 2010 NORTH EAST, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility CROUCH FUNERAL HOME 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Onset and Death
Unbruwn shock, or heart failure. List only one cause on each line Immediate Cause (Final Due to (or as a consequence of): Priysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death the 9 I Inknown 9 Unknown been signed by 1 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy certificate Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Matural injury 5 Pending 1 🗌 Yes n 24 hours after death.

The Funeral Director: A pleted filled in by the funeral pleted in by th 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 12.7.2010 Vachder 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S. SHCUDEV M.D. 126 A. F. H. D.

Registrar DHMH 17 Rev 7/2009

State

SACHDEN MD

31. Date filed (Month, Day, Year)

DEC 1 0 2010

STIVA

32. Registrar's Signature

ElkEn MD 21921.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ Elbert Harrison Douglas 2010 12:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🙀 M 2 🗆 F Days Hours 1918 Maryland 213-16-2888 92 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director Maryland St. Mary's Charlotte Hall 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29569 Three Notch Road 20622 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural", 3 XWidowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Patrick Douglas Charlotte Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Howard Douglas/Son <u> 2392 Caledon Rd., King George, VA 22485</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12- Date Page 1 1 XBurial 2 Cremation 3 Removal from State 17-2010 Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD permit. 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Sign sure of Funeral Service License 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Acute Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ulmonary edema squer trally liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): myocal been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 2 🗌 No ours after death. eral Director; After this certificate has been signed by the s filled in by the funeral director, page 2 should be detached i q | Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D060473

State Registrar

Dova as,

Mary > Hujata

Leonardtenn no 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 + Mui

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Steven Mark Draheim December 2010 2:10 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center <u>Annapolis</u> Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Min. Country) District of Columbia Director 215-56-9754 Yrs. 61 September 3. Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛛 No Maryland Calvert Lusby 10e, Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a o Funeral 12119 Monterey Court 20657 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 3 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Government Services Elementary/Seconday (0-12) College (1-4 or 5+) Administration 12 Maintenance Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, မှ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Herbert Phillip Draheim Barbara Mae Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 548, Lexington Park, MD 20653 Barbara Jean Draheim / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State December 15 4 Donation 5 Other (Specify) 2010 Metropolitan Crematory Alexandria, Virginia July of Funeral Service Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ crrrhosis iver disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _ in the past 12 months? Pregnant at time of death Month Year 1 ☐ Yes ≥ L 9 ☐ Unknown detached Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? this certificate Yes 2 XNo 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2 🗷 No မ 1 Tes Other: 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cal Parkway anapolo MD, 21401

12/13/60

revel Bech, My

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:30 PM ,2010 ecember Betty Jane Evans Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** 1 🗆 M 2 🕱 F 2-28-1932 Gettysburg,PA Director 78 63-24-9818 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 K Yes 2 ☐ No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10q, Citizen of What Country? 9 permit. Page 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or any njury or other traumatic event, the Medical Examiner must be. Funeral 20715 United States 12008 Millstream Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ 1 Yes If Yes, Give **Black** 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during 15 Decedent's Education 16b. Kind of Business Industry Baltimore, Maryland 21215-0 (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Public Relation Specialist Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Odessa Brown George Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold G. Evans/Husband 12008 Millstream Drive Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Fort Lincoln Cemetery: 12-9-2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure, List only one cause on each line Immediate Cause (Final Colon Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir requires that the death certificate be executed for use as the burial-transi Cause Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ≥ E 9 ☐ Unknown the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 9 No Other: $4 \square$ Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year) DEC 0 7 2010

29b. Signature and title of certifier

(Check

12700 GOODLOES PROMISE DENZ BOWE NO 20120 ALEXANDER 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

052815

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edmundson Grady L. 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Cheverly Prince Georges Hospital Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign Funeral (Month, Day, 1 **X**M 2 □ F Months Days Hours Min. Year NC Director 242-54-5257 "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No Suitland PG MD 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 20746 United States Newland Road 4807 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Black Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Warehouse</u> Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edmundson Lula Barnes Hadie mit. Page 1 and 2 should b partment of Health and Mer portant: If item 27 is mark y injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) fe 4807 Newland Road Suitland, Md. 2074 Evangeline Edmundson/wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🙀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 12/10710 4 Donation 5 Other (Specify) Suitland, Md. Lincoln Memorial Cemetery Edwards F.H. 22. Name and Address of Facility Hodges & 21. Signature of Funeral Service Licenses Silver Hill Rd., Suitland, Md. 20746 3910 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 🗌 No Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 sl autops, performed 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🔄 No Other: ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

Allen

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Will

31. Date filed (Month, Day, Year)

7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Maryland /	Department of Hea		Hygiene	40656
		Registrar 1. Decedent's Name (First, Middle, La	est)		2. Date	of Death	3. Time of Death
Physicia /Medic		Darer	na Enna	15	Dec	ember 7 20	
Examin		4a. Facility Name (If not institution, gr	re street and number)	4b. City, Town, or Lo	/	4c. County of De	
			eneral Hospita	Cambr		Dorche	
Funeral		220 22 22 97	Sex 7. Age (In yrs. last I		Hours Min. (Mont		irthplace (State or Foreign Country)
Director		Usual Residence of Decedent	10		Dec	11,1755,11	aryland
From Signal		10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits 1 Pyes 2 No
Adhamarylan r 28e-f ehow	Director	MD Dorch	nester Ca	mbridge		10g, Citizen of What (
72 m	Dire	10e. Street and Number		10f. Zfp Code	12	71. C	∆
death with	Funerai	6 Mi Mo S G	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban, i	anic Origin? (Specify Yes	or No- 14. Race - An	ナ nerican Indian,
4 6 Secondary of Item	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 12 No	,	Mexican, Puerto Rican, et Specify:		
d 21215-0036 liled within 72 hours after then ther then institutel, or liter then institutel, or liter then institutel, or liter then institutel, or liter then institutel in the Medical Examina	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 LI Yes 2 LE No 3	эреспу:		lack
72 h	Completed	15. Decedent's E (Specify only highest g		6a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	on ing most of working	16b. Kind of Busines	s/Industry
within then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	Data Fin	+11/	Govern	ment
	Be Co	17. Father's Name (First, Middle, Las	1)	18	B. Mother's Name (First, N		
 agg •	To B	Aaron t	homas Ex	nals	Merita	Ennals	
Taryla 2 should and Mer 10 market	2 8	19a. Informant's Name/Relationship	(Type, Print) 1	9b. Mailing Address (Street and		4 . Y Y.	, Zip Code)
_ 5 b € 2 ±	1		Kinney	of Disposition (Name of	Court Ca	Mbridge //	1 2 6 10
	8	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from State	tery, crematory or other place)		1 1	
Baltimol permit. Pages Department of Impoparamt: If it any injury or o		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		22 Name and Address	of Facility		3ge /11/1
Balti permit. Departrimports any Injures		Jane 100.	C. Dlowry	Henry fu	neral Itan	- Cambrid	- MD, 2/6/3
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that ceused the death. D				Approximate Interval Between Onset and Death
Physician	Š.	Immediate Cause (Final disease or condition	47/4800	10000 ato a	40-27	- Desamo	Onset and Death
/Medical		resulting in death)	a. Due to (or as a consequence	ce of):	11120		
Examiner	lu.	Sequentially list conditions,	b. — Due to (or on a consequence	oo of):			1
pe #sc	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	Se OI).			
execut and al-tran	xan	that initiated events resulting in death) Last	c Due to (or as a consequence	ce of):			
8760, sate be exphysician the burial	cal	· ·	d				
688 riffical ng phy as th	Medi	IF FEMALE:					
Box 61 eath certific	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3 □Ectopic pregnancy		23d. Date of o	delivery Day Year
P.O. F hat the dea d by the a	Physician/Med	1 ☐ Yes 2 X No 9 ☐ Unknown	4□ Pregnant at time of death 9□ Unknown	5 Other (specify)			
P. P.	Ph	Part II. Other significant conditions	contributing to death but not resultin	g in the underlying cause given	in Part I. 23e	Did tobacco use contribute	to the cause of death?
rds. quires n sign	d by	Hype	etinseen			1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Unknown
aw rec	piete	Dy	lipedemia		24a	Was an autopsy 24b. Were	autopsy findings available to completion of cause of
The late ha	Completed				1 🗆	performed? death	? ′es 2□ No
/ita	Be	25. Was case referred to medical examiner?	11		26. Place of Death (Check	only one)	
Of V Physic this c	2	1 ☐ Yes 2 No 27. Manner of Death		Outpatient 3 DOA Other:		Residence 6 Other (S cribe how injury occurred	pecify)
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Division of Vital Records, if or Attending Physician: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	fica	3 ☐ Suicide 6 ☐ Could not	be Gas Blace of Initial At home	, farm, street, factory, office	28f. Loca	tion (Street and Number or or Town, State)	Rural Route Number,
Div s afte	Certification;	4 Homicide	Building, etc. (Specify)			29822	
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	(Check only 2 Medical Ex	Physician: To the best of my knowled miner: On the basis of examination	dge, death occurred at the time, and/or investigation, in my opin	, date and place, and due nion, death occurred at the	to the cause(s) and manner time, date and place, and c	as stated. due to the cause(s)
the h	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License r	number	29d. Date signed (Mo	onth, Day, Year)
To To To Colo		MAL AARO	MD	DA	53359	12/71	10
6	1	30. Name and address of person wh	o completed cause of death (Item 23	a) (Type, Print)		1	0.1.0
		MAHBUBA	AKHTER , &	503 BYRN	ST, CAME	HRIDGE, M	D-21613
Sta Registi		31. Date filed (Month, Day, Year) DEC 09 2	32 Registrar's Signature	park			
negisti	ell	V V V	harmen la				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) December 9, 2010 2:50 A M Margaret L. Frank 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Homewood at Crumland Farm Frederick Frederick 8. Date of Birth (Month, Day, Year Dec 25, 19 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 🕅 I 228-28-5417 83 1926 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 1 XYes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7407 Willow Road, #257 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Communication Satellite 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Karns Loretta **McCoy** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Frank/son 30539 Bennett Road Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/13/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Juanto Kyhomoo M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Gnemia 2 □ No 3 Probably 4 ☐ Unknown 1 ☐ Yes disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2⊡No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Déath 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Physician/Medical use as Completed by Be

Physician

/Medical

Examiner

Funeral

Director

Examiner must be notified at

other traumatic event, the Medical

Important: If It any Injury or c

Physician

/Medical Examiner

or items 23a

e filed within 72 hours after oal Hygiene. I Ather than "natural", or ite

ould be fi Mental F n and Mental

Baltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records,

death 1

Director

Funeral

Completed by

Be

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Examiner the burial-trar ို ospital or Attending Phous after death. Certification:

3 ☐ Suicide

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

4 Homicide

29a. Certifier

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Montclaire Ave Frederick MD 21701

State Registrar

To the Hospital or within 24 hours at To the Funeral D

Syed Hag 31. Date filed (Month, Day, Year) DEC 1 0 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ December 2010 Elaine C. Flemion 4:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10218 Green Clover Drive Ellicott City Howard Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months 1 🗆 M 2 🖾 12/15/1934 579-44-9056 75 **Director** Usual Residence of Decedent il Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 XNo MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10218 Green Clover Drive 21042 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Director Office of Aging Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Wymer Bonnie Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip D. Flemion - husband 10218 Green Clover Drive Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Marriottsville, MD 12/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem.Gard. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Opset ariu - 9 MonThi set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a o uence of): Examiner Months 00 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No cate has been signed by the atter-Month Day Year 5 Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate I 2 No Yes 2 1 🗌 Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending after death. Director: Af 1 Tes 2 🔲 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State 24 hours a Medical 29a. Certifier Scrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 346 Mil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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WW)

32. Registrar's Signature

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31. Date filed (Month, Day, Year

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Political	Certificate of Death	Reg. N	0010	40659
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Velma Mae Farmer		2. Date of Death Month	Day Year 13, 2010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	7 17 17 17 17 17 17 17 17 17 17 17 17 17	13, 2010 1c. County of Death	5:59 p ^M
rpd			65 Linton Run Road	Port Deposit		Cec	
	Funeral Director		5. Social Security Number 415-36-7567 Usual Residence of Decedent	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year May 26,	9. Birthp Count 1 ei	lace (State or Foreign ny) 1nessee
	faryland Ba-f show tified at	ector	10a. State 10b. County 10c. City, Town	or Location Port Deposit		10	Od. Inside City Limits 1 ☐ Yes 2 💢 No
	with the M s 23a or 24 ust be not	Funeral Director	10e. Street and Number 65 Linton Run Road	10f. Zip Code 21 904	10g. (Citizen of What Count	-
030	s filed within 72 hours after death with the Maryland tal Hyglene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ◯ ◯ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto □ Yes 2 【 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Wh	
9500-912	in 72 hour e. nan "natul Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	L	ing 16b.	Kind of Business Ind	ustry
7	filed withi al Hygien d other th	Be Co	Elementary/Seconday (0-12) TWE I VE YEARS 17. Father's Name (First, Middle, Last)	Supervisor	Tina Mining Marine	<u>Toll Faci</u>	lities
lan	d be file Aental I Irked c Iic eve	일	Roy Butler Hammons		e (First, Middle, Maide Emma Willi		
, maryland	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en			Mailing Address (Street and Number or Rura Linton Run Road, Po			
saitimore,	ge 1 an nt of He ; If iten or oth		1 N Burial 2 Cremation 3 Removal from State cemetery	crematory or other place)	1	Location - City or To	
aitiir	mit. Pa bartmer bortant r injury		4 ☐ Donation 5 ☐ Other (Specify) St. Ma 21. Signature of Funeral Service Loene	ark's Cemetery 12/1		ryville,	
ñ	an per		Shomes N. + all tisson, Sr.	22. Name and Address of Facility Lee A. Patterson & Perryville,	Son Funer Maryland	`al Home 21903-076	P.A. 6
Y,	nysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Preumonia	or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner	<u>.</u>	Due to (or as a consequence of):			
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or linjury that initiated events c.				
00/	te be exe nysician a he burial-	dical E	resulting in death) Last Due to (or as a consequence of d):			
20x 08/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 64 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	ry Day Year
S, P.O.	uires that th n signed by ıld be detac	by	Part II. Other significant conditions contributing to death but not resulting in Pleuval effusion Acute	the underlying cause given in Part I. Myo Cardial		use contribute to the	
Records,	The law require has bee bage 2 shou	Completed	infarction, HYPERTEN.	SiON, C.A.D.	24a. Was an autopsy performed?	prior to con death?	sy findings available apletion of cause of
VITAL	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		NO TES A	Z EX NO
Z Z	r this caral dire	e: 10	1 ☐ Inpatient 2 ☐ ER/Outp 27. Manner of Death 28a. Date of injury 28b. Tir	and the second	me 5 Residence 28d. Describe how inju		
Division or	ttending death. :tor: Afte / the fune	Certificate	2 Accident Investigation 3 Suicide 6 Could not be	work? M 1 🗆 Yes 2 🗆 No			
	pital or A ours after eral Direc	_	4 Homicide determined 28e. Place of Injury - At home, farn building, etc. (Specify)	,	28f. Location (Street a City or Town, Stat	re)	0
	the Hosi hin 24 ho the Fune npleted f	Medical	29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the best of my knowledge, de only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, de only one)	investigation, in my opinion, death occurred at dge, death occurred at the time, date and plac	the time, date and place, and due to the cause	ce, and due to the cause(s) and manner as sta	se(s) and manner stated. ted.
	vit oo col		29b. Signature and title of certifier SURESH DHANJANI MD	29c. License number	29d. D	ate signed (Month, D	ay, Year)
	8		30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)		-11/12	44300:
	Stat	e	31. Date filed (Month, Day, Year)	2 S. UNION AVE, HA	IVRE DE	GRACE,	MD21078
	Pogietro		DFC 1 5 2010 /2 A Back				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2010 Physician/ December 7am Michael Francis Finan Jr. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner ShadySide Anne Arundel 4951 Elm Street 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Washington DC 1 😿 M 2 □ F 1277474930 79 579-48-9029 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 28a-f shor 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Anne Arundel MD ShadySide 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20764 4951 Elm Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? þ 1 Never Married 2 X Married 1 X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 9 Defense Mapping Agency Cartographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or cat. ၉ Michael Francis Finan Sr. Florence B. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4951 Elm Street ShadySide, MD 20764 Carole Frances Finan Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 17 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 12/15/2010 Maryland Veterans 22. Name and Address of Facility Signature of Juneral Service Licenses 12 Ridgely Annapolis, Aye MD 21401 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAY Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to lor as a consequence of) if any leading to immedicause. Enter Underlying burial-transit Cause (Disease or iinjury The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Pregnant at time of death 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DILATED 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed Yes 2 page 2 s death? PERTEN 1 Yes 2 No certificate 26. Place of Death (Check only one) Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical director, Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) examiner Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number certifier 29b. Signature and title 36091

State Registrar BESTGATE RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:30 FM James Samuel Farr 2010 December 11 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown 8. Date of Birth (Month, Day, Yea May 12, 19 Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 🛣 M 2 🗆 F Months Hours Min. Country) Maryland 1924 218-24-1141 86 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 K No Leonardtown St. Mary's Maryland . 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20650 USA 39350 Montpelier Lane Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file Amy Gertrude Swann Benjamin McKinley Farr and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 39350 Montpelier Lane Leonardtown, Maryland Ruth Farr/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State December 16, 4 Donation 5 Other (Specify) 2010 Morganza, Maryland St. Joseph's Cemetery of Funeral Service Licens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home P.A. 20650 P.O. Box 270 Leonardtown, Maryland 23a. Part t Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician L'is eumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Kena awantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has performed To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🔲 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of D60888

5 pm

DHMH 17 Rev 7/2009

State Registrar Leonardtown, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Rakhi Krishnan 26840 Point Lookout Road

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 13, 2010 Harolene Elorise Glotfelty 4:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Garrett Goodwill Mennonite Home Grantsville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Days Oct. 17 Year 1918 Mary Tand Min 213-64-9909 92 Yrs. **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 X No Garrett Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 378 Glotfelty Lane 21520 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, à 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Wade McLean Bertha Savage 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Glotfelty Lane, Accident, MD Arlene Beitzel/Daughter 21520 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bumble Bee Ridge Cem. Dec. 16, 2010 Accident, MD 20c. Location - City or Town, State ō 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. me P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 N of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death.

e Funeral Director; After the function of the functin Division 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете 2 Medical Examiner: On the basis of examination and/or investigation, in tily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ()(] 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Thomas Johnson, 311

DEC 14

31. Date filed (Month, Day, Year)

N. Fourth St., Oakland, MD

Registrar's Signature

Physici		1- For State Registrar		Ce	rtificate of	Death				g. No.		056
		1. Decedent's Name (First, Midd		6.66					Date of Deat Month December			3. Time of Death 0929 hrs
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 \			. Date of Birt	h (MM/DD/YYY)	Y) 9. Birth Foreign	hplace (State or
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should and M 7 is m	To	19a. Informant's Name/Relations										, MD 20653
and 2 lealth tem 2 traum		Teresa M. Mila 20a. Method of Disposition			Place of Dispos	ition (Name of			ate	20c. Location	- City or	Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 20/0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSP. ROCKVILLE Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, MAY 10 1**X**□ M 2 □ F 297-84-1513 32 Director 978 OHIÓ Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. MONTGOMERY BETHESDA N. 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5440 MARINELLI ROAD #440 20852 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes : 2 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 🗌 Widowed 4 🗌 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CARTOGRAPHER NATIONAL GEOGRAPHIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ DAVID GARDNER JILL SNYDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5440 MARINELLI RD., N. BETHESDA, MD. 20852 RUTH BRINGMAN GARDNER-WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) METROPOLITAN CREM. 12/11/2010-ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2222 – WISCONSIN AVE., NW Signature of Funeral Service Lige WASHINGTON, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical 2 days Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Unknown g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 X No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No this certificate 2 🗌 No 1 Tes To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Curtifying Nurse Practiceon To the best of my Includedge, deeth became at the time, date and place, and due to the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2010 70834 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe

State Registrar DR.M.

31. Date filed (Month, Day, Year)

HEPPER

Registra 's Signature

SHADY GROVE ADVENTIST HOSPITAL, ROCKVILLE, MD. 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	State of M	laryland			of Healtr of Deat			eg. No.) 0	6000	
	Physici	an	1. Decedent's Name (First, Midd						2	2. Date of Dear Month	Day	Year	3. Time of Death	
	/Medic		JANE CASKEY G 4a. Facility Name (If not institution		r)		th City To	wn, or Locatio	n of Death	11-2		ounty of Death	7 803	
	Examin	er	MEMORIAL HO				40. Oity, 10	EASTO		TALBOT				
	Funeral		5. Social Security Number		ge (In yrs. la		If Under 1	Year If Und		3. Date of Birth) Voarl		place (State or Foreign	
	Director		224-58-5182	1 □ M 2 X) F	96	Yrs.	Months [Days Hour	Min. 0	B. Date of Birth (Month, Day 2/24/19	914		OH	
	Pu ,		Usual Residence of Decedent		10. 01.	T	A					1.	0d. inside City Limits	
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Macial Evarinat must be notified a once.	by	1 ☐ Never Married 2 ☐ Ma 3 🕱 Widowed 4 ☐ Divorce	Armed Forces 1 Yes 2 if Yes. Give	? 【No		es, specify Yes 2 ✓			icán, etc.)			HITE	
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22 E	hould od Me mark matic	ပ္	FREDERICK ANT 19a. Informant's Name/Relation			19b Mailing	Address (5					Town, State, Zij	c Code)	
Goυsen, Marylan	nd 2 s Ifth ar 27 is r trau		ANN G. KILLALE	, , , , ,			•					, VA 22		
(1)	s 1 ar f Hea ftem other		20a. Method of Disposition		20b. Pla	ce of Disnosi	ion (Name	of	Da			ation - City or To		
lawe' timor	Page: nent o nt: If ry or		1 ☐ Burial 2 📉 Cremation 4 ☐ Donation 5 🖵 Other (-		CHES	Metery creme SAPEAKI NTER	CRE	MATTON	12/02/	2010	STEVI	ENSVILLI	E, MD	
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sio	Attending ir death ector: After by the fune	catio	2 ☐ Accident invest	tigation			М	1 ☐ Yes 2						
Division of Vital Records,	tal or Att rs after d al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	:_ ZOE. Flace OI II	njury - At hon etc. <i>(Specify)</i>	ne, farm, stree	t, factory, c	office	2	8f. Location (S City or Tow	itreet and n, State)	l Number or Rui	al Route Number,	
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	12		30 Name and address of person	n who completed cause of	death (Item	23a) (Type, P	rint)	٨				1	TA	
	14		YAULM. KEIS	HBOLD WD 3	218	LOOMIN	6DA	LE HUE	. LED	2AL	2B1	R6, 1	WD	
	Sta	te	31. Date filed (Month, Day, Year	r) 32. Regis	trar's Signatu	ire								

State Registrar DEC 0 2 2010 Senter B. Spark

Physician Medica Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

•	1 - For AMEND#25, 27, 28a-: Registrar	State of M fperMD, HMW, M	aryland bCo		ment of Ficate of E		vientai my	Reg. No.	010	406	66
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al er	4a. Facility Name (if not institution, give			4		Location of Death		4c. Cc	ounty of Death		
	Holy Cro. 5. Social Security Number 6. So	ss Hospita	U e (In yrs. lasi	hirthday)	S/ f Under 1 Year	ilver Sp.	rung 3. Date of Bir	th	Montgomery 9. Birthplace (State or Foreign		
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Completed by Funeral Director	10e. Street and Number 10602 Lilac P	lace			10f. Zip Code	20903		10g. Citizer	n of What Cour		
/ Fur	11. Marital Status	12. Was Decedent Armed Forces?		13. Was	Decedent of Hi s, specify Cuba	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14.	Race - Americ Black, White,		
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To Be	17. Father's Name (First, Middle, Last)	- 0 '	~ ~			18. Mother's Nar					
_	W.L.L.am 19a. Informant's Name/Relationship (7)	E. Gaine	5, 11	401 14-11		nd Number or Ru		<u>Grun</u>		2040)	
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	4 Donation 5 Other (Specif	(y)	Ft.	Lincol	n Crema	tory 12/	13/2010	Brent	wood, N	laryla	nd
	21. Signature of Funeral Service Licens	mell				s of Facility Hi Hampshir					
	23a. Part 1. Enter the disease, or com- shock, or heart failure. List only o	plications that cause ne cause on each lin	the death.	Do not enter t	ne mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximat Interval Bet	ween
	Immediate Cause (Final disease or condition resulting in death)	a. Left 1	lip Fr	acture						Onset and I	Death
_	Sequentially list conditions,		stive Heart Failure						y C	3mg	
edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury		a consequence of):					On			
al Exe	that initiated events resulting in death) Last	Due to (or as	a conseque		1	, 3	JU'	15	191	0	
edic		Id. Pneumo	inca			100		7	1 1		
Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal of	death 3 🗌 E	ctopic pregnanc other (specify)	,,,,		230	d. Date of delive		Year
Ş.	Part II. Other significant conditions c	J.		ting in the und	erlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to th	ne cause of d	leath?
ted	Acute Myocardia	l Infarct	Lon				1 🗆		No 3 Prol		
mple								opsy ormed?	death?	mpletion of o	available ause of
ပ္သ	25. Was case referred to medical				26. Pla	ace of Death (Che	_	2 X No	1 Yes	2 🗆 No	
To Be	1 ZN Yes Z IZE NO			R/Outpatient	3 DOA Othe	er: 4 🗌 Nursing l	ome 5 Res	idence 6	Other (Specify)	
ate:	27. Manner of Death 19 Notural 5 Pending	28a. Date of inju	y, Year)	8b. Time of injury	28c. Injury work M 1	rat ? Yes 2 🔀 No	28d. Describe		ccurred		
ij	2X Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	28e, Place of Inj	ury - At hom	unknown e, farm, street		165 2 2 110	Fall-acc	Street and N	lumber or Rurai	Route Num!	ber;
ဦ			me				10602 Li		Silver S)
Medical Certificate:	(Check 2 L Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination a	and/or investiga	ition, in my opinic	n, death occurred	at the time, date	and place, ar	nd due to the ca	use(s) and ma	anner stated.
_	29b. Signature and title of certifier	ng (ra	1	29c, License	number 060826			ember 0		1.0
	30. Name and address of person who									7, 40	
e	Kshama Garg, M. 31. Date filed (Month, Day, Year)	V., 1500 32 Registr	orest ar's Signatu	e den	Koad, S	uver Sp.	ring. MI	2091	U		
r	DEC 07 20	10 Separ	ar's Signatu	A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gosnell Diana Jane 19:30 PM December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢F 577-56-0499 Hours (Month, Day, Year) Sept. 21. Maryland 69 Director ...1941 Usual Residence of Decedent 28a-f shov 10a State 10h. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severn 1 Yes 2 X No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7821 Shallowbrook Court 21144 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ō þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 😾 No Specify: "natural" Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Port Director U.S. Immigration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Reginald W. Quinn Dora L. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Alan Gosnell / Son 3923 Apple Orchard Drive Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Lakemont Memorial 07 Donation 5 Other (Specify) 2010 Davidsonville, MD Gardens 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 2 days Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): **Examiner** Due to (or as a construence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inigury that initiated events Edem Examiner attending physician and for use as the burial-transit certificate be executed Mygradial I
Due to (br as a consequence of) In farction resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End- stage renal disease, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Diabetes mellitus, Peripheral vascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe hours after death. Ineral Director: After this certificate 2 No Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician:

Within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1558688333 December 2, 2010

DHMH 17 Rev 7/2009

State Registrar

Hospital of

Baltimore

completed cause of death (Item 23a) (Type, Print)

strar's Signature

D.0

32. Registrars

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DEC 0 7 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ REENE Month 2010 Medical 340 4a. Facility Name (if not institution, give street and number) Examiner b. City, Town, or Location of Death 4c. County of Death ounty (somery Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Days Director Hours Min. 08-16-1960 220-80-143 Yrs. 50 Maryland Usual Residence of Decedent 10a. State be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Md. Dorchester Hurlock 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 501 Penn Street 21643 or items USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. "natural", 3 🗌 Widowed 4 🗌 Divorced If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) Teamster College (1-4 or 5+) Local #355 Bus.Agent/Organizer injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) and Mental ! 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Adams Janet Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Department of Health a Important: If item 27 is any injury or other trains Shareen B.Camper Greene 501 Penn Street, Hurlock, Maryland 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Md. Veterans Cem. 12-13-10 4 Donation 5 Other (Specify) Hurlock, Maryland Signature of Firm Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 516 S.Main St., Hurlock, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) 01 7 Medical Due to (or as a consequence) Examiner sorlansi Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a co burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as the the attending IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery for in the past 12 months? Pregnant at time of death 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate perform death? Yes 2 No 1 Yes 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? 은 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Accident Investigation M 2 🗆 No within 24 hours after deat To the Funeral Director, Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis Certifying Nurse Practioner: To xamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sid nse number 163 e and addre of person who se of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar's Signature 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death December 3, Physician/ 2010 7:59 рм Barbara Jean Haskell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Hyattsville St. Thomas More Medical Complex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth Funeral Min (Month, Day, Year) ulv 3, 1938 1 🗆 M 2 🕱 I Director 72 579-50-1180 July Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral United States 20020 1420 Bangor Street SE 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates American Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working (Specify only highest grade completed) other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) Mental Hygiene. the Order Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Vance Singleton Bessie Henderson and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Rhonda Turner - Daughter Bangor Street SE Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State December 15 2010 Harmony 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland ture of Funeral Service Lin 21. Sig Stewart Funeral Home, 4001 Benning Road NE Washington, DC 20019 23a. Part t. beter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arterosclerotic Cardiovascular Disease disease or condition vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be Cerebral Infarction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Encephalopathy Respiratiory Failure Jas autonsy page performed? Yes 2 No certificate l Coronary Artery Disease 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗵 No Hospita Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After Hospital or Attending injury 1 X Natural 5 Pending safter death. 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 8, 2010 D01852

CR 2

DHMH 17 Rev 7/2009

Registrar

4203 Queensbury Road Hyattsville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DeVore M.D.

Paul A.

31. Date filed (Month, Day, Year)

DEC 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER Day 6 2010 VERNELDA TAYLOR HARRIS 11:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10303 FOX DALE COURT BOWIE PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours JULY 25 1960 1 □ M 2 🙀 F Director WASHINGTON, DC 579-84-4951 50 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD PRINCE GEORGE'S BOWIE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10303 FIX DALE COURT 20721 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12TH EXECUTIVE ASSISTANT **GOVERNMENT** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ f item 27 is marker r other traumatic JAMES GARLAND FULLER JULIA ETTA GREEN I and 2 should b f Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10303 FOX DALE COURT BOWIE, MARYLAND RALPH LYNN HARRIS/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State RIVERDALE CREMATORY 12/10/2010 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MARYLAND 2 V Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: After this certificate has been signed by the attendin funeral director, page 2 should be detached for use. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 1 Yes 2 🗶 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗷 No Hospital Other: 1 🗌 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work? 1 Yes 2 No after death

Director; A

I in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29h Sid nature certifie 29c, License number 29d. Date signed (Month, Day, Year) DECEMBER 7, 2010 D41276

State

Registrar

4710 AUTH PLACE SUITLAND MARYLAND

20746

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

PAUL WILSON M.D.

31. Date filed (Month, Day,

DEC 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 01 Month 12 2:30 PM 2010 James G. Higginbotham Physician/ 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 6526 Greenmount Drive Elkridae Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Hours Min 12/29/1918 Days Funeral Months VA 1 🙀 M 2 🗆 F 91 215-09-9995 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State 1 🔀 Yes 2 □ No Director Elkridge Howard MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21075 Funeral 6526 Greenmount Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status 1 Ves 2 No. If Yes, Give WWII Year or Dates. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Specify: Black Baltimore, Maryland 21215-0036 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Private Elementary/Seconday (0-12) Steel Worker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Amanda McDaniel ပ David Higginbotham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4532 Hemlock Cone Way, Ellicot City, MD 21042 Marlene Waddy/Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Columbia, Maryland Columbia Memorial Pk: 12/6/2010 4 Donation 5 Other (Specify) Latimore Funeral Services 22. Name and Address of Facility 21. Signature of Funeral Service License 9013 Annapolis Rd., Lanham, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pneumonia Immediate Cause (Final Physician/ disease or condition Due to (or as a consequence of) Medical resulting in death) Congestive Heart Failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examiner Dementia attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Debility Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 5 Other (specify) in the past 12 months? detached for Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 XUnknown þ Renal Failure Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a, Was an autopsy performed? Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, **Division of Vital** Be Other: examiner? 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 2 **X**No 1 Yes မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 24 hours a Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the l within 2 To the f only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 12/03/2010 053987 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Armory Place, Baltimore, MD 21201 Kenneth Geh, MD 32. Regis ar's Sig 31. Date filed (Month, Da Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Los State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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		Registrar	Certificate d	Dealli	Reg. i		
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Shuk			Date of Death Month Date December 16	5, 2010 0653 his	
A. Carrier		4a. Facility Name (if not institution, give street and South Bound Winchester Road at (4b. City, Town, or Location of Dea Cresaptown	th	4c. County of Death Allegany	
Funeral Director		5. Social Security Number 218-84-7184 Usual Residence of Decedent	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours M		IM/DD/YYYY) 9. Birthplace (State or	
nrs after death with the Maryland ural", or items 23a or 28a-f show any miner must be notified at once.	by Funeral Director	10a. State MD Allegany 10e. Street and Number 342 National Highway 11. Marital Status 12. Was I	Decedent Ever in U.S. 13. W I Forces? If s 2 No Year 1	ation /ale 10f. Zip Code 21502 /as Decedent of Hispanic Origin? (Section of the Company of t	Specify Yes or No- to Rican, etc.)	10d. Inside City I 1 X Yes 2 Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 5. Kind of Business/Industry	No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menfall Hygiens I Department of The The The Theorem of the Theorem of the Theorem of the Theorem of the Theorem injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once	To Be Completed	12 17. Father's Name (First, Middle, Last) Shukry Hijab 19a. Informant's Name/Relationship (Type, Print) Ramona Hijab 20a. Method of Disposition	Daughter 19b. Mailing 19b. Mailing 32 I from State Restlawn M.	nest of working life. DO NOT use respectively. Item/Operator 18.Mother's Name of Address (Street and Number of Pacific Name of Cemetery, Ither place) Page and Address of Facility Name and Address of Facility	ne (First, Middle, Maid et A. (Halal Rural Route, Number ay LaVa	The Clock Shop en Surname) by) Hijab City or Town, State, Zip Code) alle MD 215	502 MD
Physician /Medical zxaminer	Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	t caused the death. Do not enter iple Injuries s a consequence of): s a consequence of): s a consequence of):	Scarpelli Funeral 108 Virginia Avei the mode of dying, such as cardiac	nue: Cumberlai		
ords, P.O. Box 68760, requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial - transit	by Physician/Medical	1	s, outcome of pregnancy birth 2 F gnant at time of death 5 C known	etal death 3 Ectopic pregrether (Specify) underlying cause given in Part I.	23e. Did tobac	23d. Date of delivery Month Day Year co use contribute to the cause of death No 3 Probably 4 Unknown 24b. Were autopsy findings ava prior to completion of cause	h? nown
Division of Vital Records, P.O. Box 68760, To the Hopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical Certification: To Be Completed	1 Natural 2 Pending Investigation 2 Suicide 6 Could not be determined (Special Check only one) 2 Medical Examiner: On the base of the suicide (Mod 12-28e. Plane 1 Could not be determined (Special Check only one) 2 Medical Examiner: On the base of the suicide (Mod 12-28e. Plane 12-2	pest of my knowledge, death occurs of examination and/or investigation	Injury 28c. Injury at Work? 1 Yes 2 No eet, factory, office building, etc. urred at the time, date and place, ar	performed 1 Ves 2 conly one) ing Home 5 Res 28d. Describe how unknown 28f. Location (Stree or Town, State Cresaptor) d due to the cause(s)	death? 1 Yes 2 N idence 6 Other Scene injury occurred read Number of Rura Regist Number Chad Cadd Cadd Cadd and manner as stated.	No
To You To To To To To To To To To To To To To	Me	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed calcaron Locke MD. Assistant Media) ause of death (Item 23a) cal Examiner 111 Pen	29c. License number O.C.M.E. n Street, Baltimore, MD 21	D	d. Date signed <i>(Month, Day,</i> Year) ecember 17, 2010	
Si Regis	tate trar	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	Ann. N. J			
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State of Maryland / Department of Health and Mental Hygiene 1 1 1 6 7 3

					C	Certificate of	f Death	Re	g. No.	J	.0070
		o _r ,	1. Decedent's Name (First, Middle, La	1 1				2. Date of Death	Day	Year	3. Time of Death
	Physici * /Medic		Brian Hi	nkle				Decembe		2010	1030
	Examir		4a Facility Name (If not institution, give					Location of Death	4c. County		_
			Bowie Health	Center			Bowie	,	Princ	ce (reorge's
	Funeral		5. Social Security Number 6. 5		(In yrs. last birtho	lay) If Under 1 Yea		S. 8. Date of Birth	Vaarl	9. Birthpla	ace (State or Foreign
	Director		217-44-6412	K∐M 2□F	63 Yrs	Months Day	s Hours Mir	s. 8. Date of Birth (Month, Day, 1/15/19	47	Mary	
	D		Usuel Residence of Decedent								
	how i		10a. State 10b. County		10c. City, Town o	r Location				10	d. Inside City Limits
	Ma F	ᅙ	MD Prince G	eorge's	Bowie						1X□Yes 2□No
	1 2 2 E	- E	10e. Street and Number			10f. Zip Code)	10	g. Citizen of V	Vhat Count	ry?
	15 w 1	Funeral Director	4107 Crosswick T	urn		2071	5		USA		
	dea dea	Je.	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. Was Decedent of	f Hispanic Origin? (Specify Yes or No-		e - America k, White, e	
)	after or h	교	1 Never Married 2 Married	1 ☐ Yes 2 💆 N If Yes, Give	0	1 ☐ Yes 2X N		Tio Tilouri, Oto.)	4.000		
Š	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "hatursl", or thems 23s or 28s-f show event, the Medical Examiner must be notified at	Ď	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		10103 2210	o specif.		Specify	Whit	te
֡֡֝ <u>֚</u>	72 h netu	Be Completed	15. Decedent's E (Specify only highest gro	ducation	16a. D	ecedent's Usual Occ Give kind of work don fe. DO NOT use reti	upation	orkina	16b. Kind of Bu	siness/Ind	ustry
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ב ב	E T T T	Be	17. Father's Name (First, Middle, Last)				ame (First, Middle, N		Θ)	
<u>×</u>	Man Man	٩	Ray O. Hinkle				Eliz	abeth Ben	nett		
Maryland	sum sum		19a. Informant's Name/Relationship	** .				Rural Route Number,			<i>Cod</i> e) 20715 ∣
	1 end Health em 27		Ellen G. Hinkle	e / Spouse		07 Crossw	ICK TULII		Bowie,		
baitimore,	ges 1 e		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Damoval from State	20b. Place of D cemetery,	isposition (Name of crematory or other p		1	20c. Location -		
<u>Ē</u>	LT THE		4 □ Donation 5 □ Other (Special		Metro C	rematory		12/6/10			MD.
<u>a</u>	parmit. Peg Departmant Important: i any injury c		21. Signature of Funeral Service Lice	nsee		22. Name and Add	Iress of Facility	seall Fune			
a	20 E 2 9		1/del			6512 NW	Crain Hwy	Bow	rie, MD	207	15
	ALC: N		23a. Part . Enter the disease or com	plications that caused	the death. Do not	enter the mode of d	ying, such as cardi	ac or respiratory arre	est,		Approximate Interval Between
F	Physician		STOCK, or Heat Reliate. List only							1	Onset and Death
	/Medical		Immediate Cause (Final disease or condition	Asso	withour	INT				1	
	Examiner		resulting in death)	a	Cute to (or as, a coi	nsequence of V				1	
		ner		Ane	todas	Ass	eit				
	certificata ba axecuted rding physician and use as the bunal-transit	edicai Examiner	Sequentially list conditions	b	Due to (or as e cor	nsequence of):					
o`	an ar rial-t	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·						į	
08/P0	tabe ysici nebu	cal	Cause (Disease or injury that initiated events	C	Due to (or as a cor	nsequence of):				1	
õ	as th	Med	resulting in death) Last							1	
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		Ph sician	Part II. Other significent conditions of	ontributing to death bu	t not resulting in th	ne underlying cause	given in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death?
7	= > m	Ę						1 □ Y	s 2 No	3 Prob	ably 4 Unknown
້ໍ	requires that the search signed by hould be dated	by						-			
Ö .	v require been sig should b	8						24a. Was ar	n autopsy	24b. We	ere autopsy findings allable prior to
		Set						perioni		cor of c	mpletion of cause death?
2	m - m	Completed						1C Ye	2 2/10	1]Yes 2□ No
	ician: The certificata rector, pag		25. Was case referred to medical				26 Place of D	eath (Check only on			7100 22310
> :		o Be	examiner?	Hospital:	nt 2 ER/Outp	atient 3 DOA	Whor:	Home 5□ Reside		er (Specifi	d
		\vdash	27. Menner of Death	28a. Date of Injur	y 28b. Tim	ne of 28c. In		28d. Describe ho			/
noision	Attending For death. • ctor: After by the funer	ig l	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju		Vonk? □Yes 2□No				
2	death ctor: A	fice	3 ☐ Suicide 6 ☐ Could not b	289. Flace of inju		, street, factory, offic	:e	28f. Location (St	reet and Numb	er or Rura	l Route Number,
5 .	din d	Certification:	4 Homicide	building, etc	. (Specify)			City or Town	, State)		
:	To the Hospital or Attent within 24 hours efter deat To the Funeral Director: completaly filled in by the	alc	29a. Certifier 1 Certifying Pt	ysicien: To the best o	f my knowledge, d	leath occurred at the	time, date end plac	ce, and due to the ca	ause(s) and ma	anner as st	ated.
:	Fur Petal	edicai	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/o	or investigation, in m	y opinion, death occ	curred at the time, da	ate and place,	end due to	the cause(s)
	within 2 To the comple	M	29b. Signature and title of certifier			29c. Lice	ense number	2	9d. Date signe	d (Month, I	Day, Year)
			1 271	$n_{\nu}O_{-}$		1)	0060	1545	Deces	n ber	. 6, 2010
	110	_	30. Name and eddress of person who	completed cause of de	eath (Item 23a) (Ty	/pe, Print)	, , ,		1	*	N 0 P1
(1	H)	Alfie Mingo	$\mathcal{V}_{\mathbf{n}}, \mathcal{V}_{\mathbf{n}}$	15001	Harth	Center	Orive	Bows	e M	10 207/6
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	park					•
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Please Type or Print in Black Indelible Ink. Fraye All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Physician/ P^{M} 1421 2010 December Medical Arnetta Lee Hughes 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Union Hospita 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Funeral Days (Month, Day, Year)
DEC 11, 1 Min. Country) Months Hours 1 □ M 2 🏋 F **Director** 195/ Maryland 217-64-4159 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Examiner must be notified at Director 1 Tes 2 X No Elkton Maryland Ceci] 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21921 248 Dogwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Rubber Manufacturing 10 Machine Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၀ <u>Doretha Jones</u> any injury or other traumatic Paul Davisson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 32804 Connie Evans/Daughter Carew Avenue, Orlando, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ferris & Co., 10 Inc 2010 West Chester 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. Stockton Street, 103 W. Approximate Interval Betweer Onset and Deat 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Duc the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 📉 မှ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Mohth, 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who

DEC 0 9 2010

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1720 ETHEL M. HIRSCH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Wicomico 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🕱 F Months Davs Hours 0778771927 Delaware 221-16-7691 Director 83 Jsual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director Maryland Crisfield 1 Yes 2 X No Somerset 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 4975 Joshua Thomas Road 21817 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify: 3 ☐XWidowed 4 ☐ Divorced "natural", Completed Specify:White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Tressler Rita Fetter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau once. 1090 Marl Pit Road - Middletown, DE Larry Hirsch (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 12/05/2010 rematory of Delmarva Delmar, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradshaw & Sons Funeral Hom 306 W. Main St. — Crisfield . Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Intracranial Hermony Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the t as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes 2 ☐ Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 \square No ည 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ☐ Natural injury work? 5 Pending 2 X No 2 Accident tall @ home Investigation 12/2/10 0800 Suicide
Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined residence 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation. in my opinion, death occurred at the time of time of the Thomas K Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of c 29b. Signatur 29c. License number 29d, Date signed (Month, Day, Year, 1450497 6/10 completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers E Carroll St. Salisbury, Md 21801 HRISTOPHER YDER 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

DEC 0 8 201

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			For State		State of Ma	ryland		partment of I		and Mer	ntal Hyg	jiene	2010) 4 0	6/6
			Registrar	Cally Leath			C	ertificate of l	Jeath	Ta		Reg. No			
5	Physicia Medic		1. Decedent's Name (First, I		Lee	j.	ten	ry			Date of Deat Month	, Da	y 2, 201	0.0	of Death M
	Examin	er	4a. Facility Name (if not insti				01	4b. City, Town, o					. County of De		
-	Funeval		Salisburg Reh 5. Social Security Number	abilite 6. Sex	ational Vi	(In yrs. las	d (+	Sali	Slove I If Under	r 24- H rs. 8.1	Date of Birth	1	O CON	CICO Birthplace (State	or Foreian
	Funeral Director		318-40-6591 Usual Residence of Deceder	0 10	M 2 🅦 F	69		Months Dave	Hours	Min.	Month, Day, une	Year)	1 0	Country) Gryland	_
	and show	I. I	10a. State 10b. Co			10c. City,	Town or	Location						10d. Inside	
	Maryl 28a-f otifiec	irec		licomi	CO		Sal	isbury						1 🔀 Y	es 2 □ No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	onega	1 c+			10f. Zip Code	804			10g. Cit	tizen of What (-	
	death item:		11. Marital Status	1:	2. Was Decedent Ev	er in U.S.	. 1	3. Was Decedent of H	lispanic Or an. Mexica	rigin? (Specify in, Puerto Rica	Yes or No- n, etc.)		14. Race - An Black, Wh	nerican Indian,	
036	's after ral", or Examir	ed by	1 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		1 Yes 2 1 1 If Yes, Give Year or Dates.	10		1 ☐ Yes 2 No			,			lack	
Henry 21215-003	2 hour	Completed	15. De (Specify only	cedent's Educ highest grade	cation completed)		16a. De (Gi	cedent's Usual Occup ve kind of work done DO NOT use retired)	ation during mos	st of working		16b. K	ind of Busines	s Industry	
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			23a. Part 1. Enter the disea shock, or heart failure.	se, or complic List only one	cations that crused cause on the line.	the death.	. Do not e	enter the mode of dyir	ng, such as	s cardiac or res	piratory arre	est,		Approxim Interval B Onset an	etween
	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a.	Due to (or as A	200000011	Ca	acen						G Ea	7
	Examiner		Commented to the conditions		Due to (or as	conseque	P oi).	Palee	7 C -				,	19ea	7-
	ed Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	₹	Due to (or as a	conseque	ence 1:						7		
	be executed sician and burial-transit	cal Exa	that initiated events resulting in death) Last	c.	Due to (or as a	conseque	ence of):								
0	ate be physic the bu	edica		d.								_		1	
687	certific ding page as	Ž	IF FEMALE: 23b. Was decedent pregnan	23	c. If <u>ye</u> s, outcome o	f <u>pr</u> egnan		_					23d. Date of	delivery	
Box 68760	requires that the death certificate is been signed by the attending phys should be detached for use as the	Physician/Medio	in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			3 Ectopic pregnand State	Cy				Month	Day	Year
P.O.	that the	by Ph	Part II. Other significant co	nditions cont	ributing to death bu	t not resu	lting in th	e underlying cause gi	ven in Part	t I.	23e. Did to	bacco ı	use contribute	to the cause o	f death?
S S	quires en sign	ed b									1 🗆 Y	es 2	□ No 3 🖪	Probably 4	Unknown
COL	2 33	Completed									24a. Was a autops	sy	24b. Were prior t	autopsy finding o completion o	s available f cause of
Re	rsician; The law r s certificate has b lirector, page 2 s	S									perform 1 Yes	med? 2 PN		res 2 No	
/ital	sician certif irector	m	25. Was case referred to me examiner? 1 Yes 2 10		spital:			Oth	er.	ath (Check only					
of V	g Physer this eral d	e: To	27. Manner of Death	1	28a. Date of injury	/ 2	28b. Time		y at	lursing Home 28d.	Describe ho			ecity)	
ono	ending sath. or: Afte he fun	ficat	2 Accident Ir	ending vestigation	(Month, Day,	rear)	injur		⟨? Yes 2□	□ No					
Division of Vital Records, P.O.	I or Atte safter de Directo d in by t	Certificate:		could not be etermined	28e. Place of Injur building, etc.			street, factory, office			Location (St City or Town			Rural Route Nui	nber,
1	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Med	ical Examine	r: On the basis of ex-	amination	and/or inv	th occured at the time vestigation, in my opini e, death occurred at th	on, death o	occurred at the	time, date an	nd place	e, and due to the	ie cause(s) and i	manner stated.
	Vithir Comp	-	29b. Signature and title of ce		ef en			29c. Licens		934	- 7			nth, Day, Year)	
	CF	Ì	30. Name and address of pe	rson who com	npleted cause of de	ath (Item 2	23a) (Type	e, Print)		<u> </u>	/		100	2:0	
	1		William H. 31. Date filed (Month, Day, Y	Robin	S M.D.		000	Civic P	tve,	Sali	SDun	41/	MD 3	21804	4
	Stat	е	31. Date filed (Month, Day, Y	and the state of) 1 32. Hegistrar	s Signatu	ire A.	Jak							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decadant's Name (First, Middle, Leat) Physician/ 2. Date of Deeth 3. Time of Death VIRGINIA ISABEL HARRISON Medical NOVEMBER 14 20Ĭ'8 0:39A 4s. Facility Name (If not Institution, give atmet and number) Examiner 4b. City, Town, or Location of Death 4c. County of Ligeth FREDERICK MEMORIAL HOSPITAL FREDERICK FREDER ICK Social Security Number Funeral If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (in yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🗓 F 9. Birthplace (State or Foreign Director 214-10-2311 1272371914 Mary Land Usual Residence of Decedent or than "natural", or items 23a or 23a-f show the Medical Examinar must be notified at 10s. State Funeral Director 10c. City, Town or Location 10d. Inside City Jamita MD Frederick Frederick 1 Tyres 2 X No 100. Stroat and Number 10f. Zip Code 10g. Citizen of What Country? 5039 Teen Barnes Road 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Givo Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amorican Indian Š 1 Never Marriad 2 Merried Black, V hilte, etc. Completed 3 X Widowod 4 Divorced 1 Yea 2 No Specify: white Year or Dates 15. Decedent's Education 18a. Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use ratired) (Specify only highest grade completed) 16b. Kind of Busini se Industry Elementary/Seconday (0-12) Collogn (1-4 or 5+) sales clerk retail Be 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maidan Sumame) marked 2 George William Cummings Florence Laura Webber 19л. Informant's Name/Relationship (Тура, Print) 19b. Malling Address (Stroot and Number of Rural Route Number, City or Town, State, Zip Code) Starr Fitez / niece 5041 Teen Barnes Rd., Frederick, MD 21703 20a. Method of Disposition

1 ABurtal 2 ☐ Cremetion 3 ☐ Removel from State
4 ☐ Donation 5 ☐ Other (Specify) 205. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery Date 20c. Location - City or Town, State Department Important Range 11/17/2010 Frederick, MD Signature of Funeral Service Liconapa 22. Name and Address of Facility Keeney & Basford Funeral Home e jour jules MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the doath. Do not enter the mode of dying, such as cardiac or respiratory prost Approximate Interval Batwaan Posat and Death Immediate Cause (Final disease or condition resulting in doath) /sician/ Atta-vecle-stic UMBOWICK F Medical Due to (or as a consequence of): Éxaminer Sequentially flat conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or linjury that inhibated events resulting in death) Leat Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and pego 2 should be defineded for use as the build-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decadant pregnant in the past 12 months?
1 ☐ Yes 2 No 9 ☐ Unknown yes, outcome of pregnancy
Live Birth 2 D Fetal down
Pregnant at time of death 23d. Date of Jalivory Pregnant at timn of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23a. Did tobacco use contribute to the bause of death? 1 Tyes 2 No 3 Tempathy 4 Tunknown 24b. Were sutopsy findings available prior to completion of cause of death? 248. Was an eutcosy Director, After this cert fixate I I in by the fureral director, pegi performed? You 2 N 25. Was case referred to medical Be 26. Place of Death (Chaok only one, examiner? Hosoital 1 Yes 2 No Certificate: To Other: 176 Inostient 2 ER/Outpatient 3 DOA 4 Numino Home 5 Residence 6 Other (Sc 32/f/) 27. Mannar of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Panding work?
1 Yes 2 No 2 Accident Investigation 8 🗆 Could not ba 28e. Place of Injury - At home, tarm, street, factory, office building, atc. (Specify) 4 L' Homicide 28f. Location (Street and Number or Fural Route Number, City or Town, State) Medical 1 Z Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as lated.

2 U Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to this cause(s) and manner stated. 29s. Certifier 3 Certifying Nurse Practioner: To the bost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner is stated 29b. Signature and title of certiflor 29c. License number 29d. Data signed (Mo: th, Day, Year) mteins MD51010 30. Name and address of porson who completed cause of death (Item 23a) (Type, Print) Tanky Frederick 21702 / Dr. Michael Toliro 31. Date flied (Month, Dsy, Youn) DEC 2 State parke

Registrar

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland		artment of H		Mental Hy	giene	Ω I Ω	10678
			Registrar			Cer	tificate of D	eath	_	Reg. No.	010	40070
_	sicia ledic		1. Decedent's Name (First, Middle, MARILYN	· ·	JOHNS	ON			2. Date of De Month DECEME		3 2010	3. Time of Death 10:47P M
	amin		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or		1	4c. C	ounty of Death	
77.00			SOUTHERN MAR' 5. Social Security Number			- 4 to 1-41 - 1 4	CLINTON If Under 1 Year	If Under 24 Hrs.	T		NCE GEO	
Fund Direct			213-66-2222	1 □ M 2 🂢 F	je (in yrs. ia:	st birthday) Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da JULY I	y, Yea <i>r)</i> 5 195	0	lace (State or Foreign try) LAND
pu wou	ŧ	٦c	Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Loc	cation				1	Od. Inside City Limits
fanyla	tified	Director	MD PRINCE	GEORGE'S	рт	ADENSB	IIDC					1 TyYes 2 ☐ No
the N	oe no	٥	10e. Street and Number	GEORGE 3	111111111111111111111111111111111111111	ADLINGD	10f. Zip Code	-		10g. Citize	en of What Coun	try?
with 18 23	unst	Funeral	4219 58TH AVE	NUE T-2			207	710		USA		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Examiner n	by	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates.		- 1	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 🏋 No		ecify Yes or No- Rican, etc.)		I. Race - Americ Black, White, e pecify: BL	
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and 2	声		KRISTEN JOHNSO	N/DGT			E. BONIWO	OOD TURN	CLINTON	, MARY	ZLAND 20	735
Baltimore, Dermit. Page 1 and Department of Hea	, i		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3	3 Removal from State	се	metery, crem	sition (Name of natory or other place	•	Date		ation - City or To	
Itin nit. Pa artmer ortant	injury		4 ☐ Donation 5 ☐ Other (So		FT.	LINCO	LN CEMETI	ERY 12/	18/2010	BRENT	FUNEDAT	RYLAND HOME, INC,
Depril Depril	any		21. Signature of Funer Pervice Lic	ense			'474 LANDO					
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that caused	the death.							Approximate
Physici			Immediate Cause (Final disease or condition	^	531V	4	Moula	rd tal	I	fur.	しから	Interval Between Onset and Death
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BOX death c		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the control	2 Fetal	death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ry Day Year
that the ned by the detact		by P	Part II. Other significant condition	s contributing to death b	ut not resul	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to the	e cause of death?
dS, quires en sig									1 🗆 🕆	res 2	No 3 🗆 Prob	ably 4 🗌 Unknown
VITAI KECOTGS, ysician: The law requires is certificate has been sig	1	Completed							24a. Was a autop perfor	SV	prior to con death?	sy findings available npletion of cause of
an: The tifficat			25. Was case referred to medical				26. Plac	ce of Death (Chec		2 2 40	1 🗌 Yes	2 L No
VITA Nysici nysici direct			examiner? 1 Yes 2 No	Hospital:	ent 2 XE	R/Outpatient	Othor		ome 5 🗆 Resid	ence 6 \Box	Other (Specify)	
IN OT ding Ph th. After th			27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investiga	28a. Date of injur (Month, Day	ry v, Year)	8b. Time of injury	28c. Injury a work? M 1 🗆 Y	at	28d. Describe h			
DIVISION tal or Attendir s after death. al Director: Af		Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be	ıry - At hom	ne, farm, stre		55 2	28f. Location (S City or Tow		lumber or Rural I	Route Number,
pital o			No. 17									
DIVISION OT VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral cirector.		Medical	(Check 2 L. Medical Exa	Physician: To the best of raminer: On the basis of exture Practioner: To the basis of the basis	kamination a	and/or investi	gation, in my opinion.	, death occurred a	t the time, date a	nd place, an	nd due to the caus	se(s) and manner stated.
P 4 4 9			29b. Signature and title of certifier	~			29c. License r	number		29d. Date s	signed (Month, D	
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C/L	T		30. Name and address of person wh	o completed cause of de	eath (Item 2	(Type, Pr	int)	o m	linton	m	00	73<
	State		31. Date filed (Month, Day, Year)	92. Registra	r's Signatui	(a	121121	1, 6	~ · · · · · · · · · · · · · · · · · · ·	,,,,	1100	
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

DEC 0 9 2010

Year)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC

68760

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 November 12:02 Lynne: Thomas Jackson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Prince George's Hospital Center Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖾 F Days Months Hours Min. Feb. 10, Year 1952 Pennsylvania 58 Director 191-42-8192 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number # 203 20019 United States 526 59th Street NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ٥ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Construction <u>Private</u> ulth and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ည Lucille Jackson unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20019 526 59th Street NE Washington, DC Brenda Jackson - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Dec Lee's 4 Donation 5 Other (Specify) Crematory Clinton, Maryland 2010 ature of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, 20019 ≠001 Benning Road NE Washington, DC 23a. Part 1. Doter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARRHYTHMIA Immediate Cause (Final CARDIAC FATAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy 1 Yes 2 No 2 X No Yes Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 X No 1 Inpatient 2 K ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No neral Director: A I filled in by the fi Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a
To the Funeral C
completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 63688 NOVEMBER 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY MD BRIVE HOSPITAL GRIFFIN DAVIS MD 3001 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 7/2009

10-09424 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 40682 State of Maryland / Department of Health and Mental Hygiene Ronald C. Johnson 1. For State Certificate of Death Rea. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day December 8, 2010 0717 hrs **Medical Examiner** Ronald C. Johnson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Prince George's Hospital Cheverly Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Months Days Hours Director Country) DC 08/17/94 579-25-4264 1 X M 2 F 16 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10h Count 10c. City. Town or Location in 1 X Yes 2 No DC s 23a or 28a-f show e notified at once, 28a-f show Washington permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatie event, the Medical Examiner must be notified at ouce. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 37th St. SE #21 20019 USA 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes Black 1 Yes 2 X No specify: Specify: 3 Widowed 4 Divorced If Yes, Give Year ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 High School Student 10th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ronald Carlton Hampton Corrie J. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 37th St SE#21 Washington, DC 20019 Corrie Johnson Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place 1 X Burial 2 Cremation 3 Removal from State 12/17/10 Brentwood, Maryland Fort Lincoln 4 Donation 5 Other Specify: 21. Signature of Funeral Service License 22ShreadAdPuneralHome & Cremation 5732 Georgia Ave NW Washington, DC 20019 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician **Between Onset and** failure. List only one cause on each line /Medical Death Cardia Arrhythmia due to Construction System Abnormality Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical **▼** UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of deliver 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 X Natural 1 Yes 2 No Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) filled determined 24 hours a Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 9, 2010 and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Vathaniel 2010 6:30 30. Α November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Crescent City Center Riverdale Prince George If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year 1 X M 2 □ F 30, 70 1940 North Carolina Director 242-62-5654 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygelens. In Propertment of Health and Martal Hygelens III in Internated the Than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Madical Examinated must be insufficed any injury or other traumatic event, Ira Madical Examinated must be insufficed at 1 XYes 2 □ No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1231 Savannah Place SE 20032 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Government Chef s 1 and 2 should be filed wi f Health and Mental Hygien Item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Burns Henry King ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 120 Mississippi Avenue SE Washington, DC 20032 Tonya King - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) December 6. 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 2010 Suitland, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign ture of Funeral Service Licen 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician JEDSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ۾ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 □No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗆 😘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner | Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely

within 2

State Registrar

29b. Signature and title of certifie

Hardy iled (Month, Day, Year)

30. Name and addr

29d. Date signed (Month, Day, Year)

and manner stated

ress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registra MEND#24aperMD, 12/8/10, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Day. 2010 20:19 Kimberly Kenney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 2, 1968 Days Hours Min. 1 M 2 T Washington, DC **Director** 577-82-5299 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Washington 1 X Yes 2 No DC 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funera 20010 United States 1372 Kenyon St., N.W. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ō ģ 1 Never Married 2 X Married Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) University 2 yrs. Student other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked of permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other trainmain. Bruce Eugene Kenney Mary Elizabeth Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1456 Oak St., N.W. #305, Washington, D.C. 20010 Mary Kenney Johnson - mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Glenwood Cemetery 12/10/10 Washington, D.C. 4 Donation 5 Other (Specify) Sign tu of uneral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W., Washington, DC 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Interval Between Immediate Cause (Final Onset and Death ardiovascular Dis Pnysician/ disease or condition YRANZ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Exami and Il-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the burialattending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Division of Vital Records, 4 Unknown Completed | 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas autopsy perform respirator certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this of in by the funeral di 27. Manner of Death

1 Natural

2 Accident

3 Sulcide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours af To the Funeral Di completed filled in Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) d title of certifier 29d. Date signed (Month, Day, Year) 218

State Registrar

31. Date filed (Month, Day, Year)

DEC

07

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 04 2010 02:30 Am Estella F. Kober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sunrise Assisted Living Annapolis Anne Arundel 9. Birthplace (State or Foreign Country) Virginia Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 - M 2 7 F Hours 1271671919 90 224-16-1795 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 nours with the Copartment of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural", or items 23a or 28a-f show Important: If them 27 is marked other than "natural", or items 23a or 28a-f show Important: If the master of the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Churchton Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5503 Harford Street 20733 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Radie Ann Arritt Andrew Lee Bess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5503 Harford Street, Churchton, Maryland 20733 Carol Murphy/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

21. Signature of the provide Licensee Cedar Hill Cemetery 12/11/2010 | Suitland, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each إنا Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ agellac Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and I-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown ed by the a 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 21 No Other: 51360 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death o the Hospital or Attending Plithin 24 hours after death.

the Funeral Director: After it propeled filled in by the funeral 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of perg completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, OEC

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 December James Arthur Lanier Sr. 4:36 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 6604 Adrian Street New Carrollton Prince George 5. Social Security Number 7. Age (In yrs. last birthday) If Unde Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours Year 1916 Virginia 94 Yrs. Director 224-14-0314 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No New Carrollton Maryland Prince George 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6604 Adrian Street 20784 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: "natural", Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Willard Elementary/Seconday (0-12) College (1-4 or 5+) 6th Customer Service InterContinental Hotel other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ည John Solomon Lanier Roberta Pegram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traignes. 20746 4102 Skyline Drive Morningside, Maryland Ida M. Lanier - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Data cemetery, crematory or other place, 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Harmony Landover, Maryland 22 Name and Address of Facility Stewart Funeral Home, Inc. 21. Sig ure of Funeral Service 4001 Benning Road NE Washington, DC Pa 1. By ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Prostate Cancer disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): -transit Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the a Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🗵 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🖾 No 1 Yes 2 🗌 No Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Hospital: Assisted Living
6 Other (Specify) Residence 1 ☐ Yes 2 🔀 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural injury 5 Pending 2 Accident
3 Suicide Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of cortiff MO70102

DHMH 17 Rev 7/2009

State

Registrar

Largo, Md.

2074

9200 Basil Court Suite 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ivan Zama M.D.

31. Date filed (Month, Day,

DEC 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		-	negistrai	Reg. N	10, 0 1 0	3. Time of Death
	Physici			Month D	ay Year	OFF SAM
	/Medic Examin		Dolly Lorraine LIAS 4a—Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	, ,	c. County of Deatl	
a di	Examin	er	Ravenward Lutheran Village Hagerstown		117-16-	
	Funeral			B. Date of Birth (Month, Day, Yea	9. Bird	blace (State or Foreign
	Director		220-18-2319 1□ M 2♥ F 85 Yrs. Months Days Hours Min.	3/14/1925		vland
	pu ,		Usual Residence of Decedent			
	show	ž	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1XYes 2 □ No
	he M	Director	Maryland Washington Hagerstown			
	with t		10e. Street and Number 10f. Zip Code	10g. (Citizen of What Co	untry ?
	eath	Funeral	217 N. Locust Street 21740 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	ifu Vae or No-	USA 14. Race - Ame	rican Indian
"	fter d r item iner	표	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Never Married 1 □ Ves 2 ☑ No	ican, etc.)	Black, White	
93	urs al	þ	3 ☑ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ☑ No Specify:		Specify: Wh	ite
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b.	Kind of Business/I	ndustry
21	within 7 lene. than "r	ğ	Elementary/Secondary (0-12) College (1-4or 5+)	,		
21	filed wi Hygier other th	ပ္ပ	6 0 Homemaker		Her own	home
and	be fill ntal H sd oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name ((First, Middle, Maide	en Surname)	
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Mary	12 sh th and 7 is n traun		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural			
	1 and 2 Health em 27 i		Walter Lias, Jr Son 1310 Deleware Lane, Hag 20a. Method of Disposition 20b. Place of Disposition (Name of Day Day Day Day Day Day Day Day	erstown,	Md. 2174 Location - City or	OState
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		•	
뜶	it. Partme		4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 12/11 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Mi			
Ba	permit. Departm Importa any inju			nnich Fur		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or		wii, Ma.	Approximate
	Db		shock, or heart failure. List only one cause on each line.	roophatory arroot,	1	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death) a. Due 6 for as a consequence of):			8 years
4	Examiner					
		je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	be executed siclan and burial-transit	Examiner	that initiated events C			
Ö,	e exe lan a urlal-t		resulting in death) Last Due to (or as a consequence of):			
8760,	sate shy:	dical	d			
9	eath certific attending p for use as	₩ec	IF FEMALE:		<u> </u>	
Вох	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of del Month	ivery Day Year
o.	at the de by the a rtached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			•
σ.	res that t signed by be detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	uires I sign Id be	d by		1 🗍 Yes	2 No 3 Pr	obably 4점 Unknown
ဝ္ပ	w requir s been s should I	Completed		24a. Was an	24h Were au	topsy findings available
æ	: The law cate has	μğ		autopsy performed	prior to death?	completion of cause of
<u>ta</u>	sician: Th certificate rector, pag	Be C	25. Was case referred to medical 26. Place of Death	(Check only one)	No 1 □Yes	⊉Mo
of Vital	.s ip	To B	examiner?	e 5 Residence	6 ☐ Other (Spe	cifv)
	De le		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	8d. Describe how in		
<u>.</u>	Attending ir death, ector: After by the fune	atic	2 Accident investigation M 1 □Yes 2 □No			
Division	- e e c	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street City or Town, St	and Number or Ruate)	ıral Route Number,
Ω	urs af ral D			·		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause d at the time, date a	e(s) and manner a and place, and due	s stated. to the cause(s)
	To the I within 2 To the I complet	Mea	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d I	Date signed (Mont	h. Dav. Year)
	ĭ ≥ ĭ °°		Manjer Fral 12 283 65	200.1	12-10-	
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
05	H-1		THAW 2 AR IS HAR 368 mill Struct H	agur.	u 191	21740
Ĭ	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	7 100		
	Registr	ar	DEC 1.3 2010 A. A.			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9 Physician/ Month 2:00 PM Charles Boone Lowe 2010 cem Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death de 6 race 0 If Under 24 Hrs. 8. Date of Birth
Hours Min.

Aug. 1, 1919 Age (In yrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 Maryland 217-05-2548 91 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Maryland Havre de Grace 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 850 Ontario Street 21078 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Charles B. Lowe, Inc. Elementary/Seconday (0-12) College (1-4 or 5+) Twelve Years Havre de Grace, MD Plastering Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles M. Lowe Olive Shallcross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles M. Lowe (son) 43 Campbell Court, Conowingo, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, Date permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Co., Inc. 12/13/10 Pennsylvánia 21. Signature of Funeral Service Licensee Lee A. Patterson & Son Funeral Home, M. somon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pitysician disease or condition resulting in death) Medical Due for as a consequence of Examiner Dertansia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to or all a consequence of Memb or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical レルピ, ヘルス/と Division of Wral Records, P.O. Box 68760 been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deal (1) MALY MU() m 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✓ nknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of prior to completion death? To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 to autopsy 2 No 25. Was case referred t Be medical 26. Place of Death (Check only one) examine 2 1 No Hospital Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manu r of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ည 12/11/12 5W TIVA address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mart /3/2010 4pm M John Dean Lewis SR. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 23 Ashcroft Ct Anne Arundel Arno1d 6. Sex If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday, If Under 24 Hrs 8. Date of Birth 1 **x** M 2 □ F 77 (479, Pay 933 579-42-7214 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland al Hygiene.
Johner than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director MD Anne Arundel Arnold 1 🗌 Yes 🗶 🗖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23 Ashcroft CT. 21012 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Yes 2 No 1951-Maryland 21215-0036 1 Yes 2 No White Specify. XX Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Appraiser Real Estate Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred F. Lewis Ada Matilda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Lewis Jr. 988 Hillendale Dr. Annapolis, Md 21409 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) 12/7/2010 Glen Burnie, MD . Signature of Funeral S 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis. MD_21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lanceme tillo genous Physician, disease or condition Medical resulting in death) Due to (or as a consequenc U f) Examine Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on sician and burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 X No 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA e Hospital or Attending Ph n 24 hours after death. e Funeral Director; After th 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗀 No Natural 5 \square Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death pocurred at the time, date and place, and due to the cause(s) and manner stated.

2 Certifying Nurse Practice or To the basis of examination and/or investigation, in my opinion, death pocurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

JOHNS HOPKINS

31. Date filed (Month, Day, Year)

DEC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIDNEY KIMMEL

29c. License numbe 01286

Dr. Karp

29d. Date signed (Month, Day, Year)

December 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. nagr 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 4:10 P.M Charles Zachariah Latham, Sr. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospice House Callaway Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☒ M 2 ☐ F Months Days Hours (Month, Day, Year) April 27,1920 Country) Maryland Director 90 214-18-8831 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "---- any injury or other than "----10a, State 10b. County 10c. City. Town or Location 10d Inside City Limits Director 1 Yes 2 No St. Mary's Leonardtown Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23275 Greenbrier Road 20650 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 X Yes 2 \(\subseteq \) No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service 12 Public Works Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Andrew Clarence Latham, Sr. <u>Jane Celeste Mattingly</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Farr Latham / Wife 23275 Greenbrier Road, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 15 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Leonardtown, Maryland Joseph's Cemetery 21. Signature of Funeral Service Lige 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a conse **Examiner** NEVNONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated as the conditions). Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit MAKINGONS Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year i signed by the ≀ 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 124 hours after death.

e Funeral Director: After this certificate has performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence (Control of the Control of the C ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural iniurv Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title. 29d. Date signed (Month. Dav. Year) 26840 Point Lookout Road #101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 20650 LEONARD TOWN SMAM strar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ALVIN MORGAN Medical ovembe 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death DOCTOR'S HOSPITAL LANHAM PRINCE GEORGE'S 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F APRIL Months Days Hours Director 579-54-6413 63 Yrs WASHINGTON.DC Usual Residence of Decedent 23a or 28a-f shov 10a. State with the Maryland 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S NEW CARROLLTON 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 5901 87th AVENUE 20784 USA "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: BLACK 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 1+ COMPUTER ANALYST PRIVATE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ OLLIE MORGAN SALLIE COLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is PHYLLIS P. MORGAN/WIFE 5901 87th AVENUE NEW CARROLLTON, MARYLAND 20784 MOrgan Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND NAT'L CEME. 12/7/2010 Donation 5 Other (Specify) LAUREL, MARYLAND 21. Signature of Fune 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to innectious cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) cate has been signed by the atte page 2 should be detached for in the past 12 months? Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 1 No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of co 29c. License number MDD5818 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Parkway Suite 101A Greenbelt, MD 20770 500 14 ANOVET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 28, William Sydney Musgrove 2010 9:53 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Center Prince Georges Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1941 Days 1 X M 2 🗆 Months Hours 68 577-54-9583 Washington, D.C. December Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10412 Slocum Court 20735 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Capitol Upholstery **Upholstery Trimmer** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William | Lucius Rebecca Strothers Musgrove 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10412 Slocum Court; Clinton, Maryland 20735 Jean Elizabeth Alford Musgrove 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Washington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Signature of Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/ Medical Examiner

Physician/

Funeral

Director

28a-f show

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items 23a or 28a-ı sırv ner must be notified at

the Medical Examiner

with the Maryland

within 72 hours after death

filed within 72 tal Hygiene.

permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important; If item 27 is marked other tany injury or other traumatic event, the once.

Maryland 21215-0036

Baltimore,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Records, P.O. Box 68760

Division of Vital

Immediate Cause (Final disease or condition resulting in death)	a. Ue to (or as a consec		'e CARLIEN	450	MAR	Disen	Interval Between Onset and Death
Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	b. Due to (or as a consector)						
resulting in death) Last	Due to (or as a consect	quence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌 Ectopi				23d. Date of del	ivery Day Year
Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Part I.	23			the cause of death?
					a. Was an autopsy performed? □ Yes 2 🔼 N	prior to death?	opsy findings available completion of cause of
25. Was case referred to medical examiner?			26. Place of Death (Che	ck only or	ne)		
1 ☐ Yes 2 No	Hospital:	KER/Outpatient 3 □	Other:	Home 5	Residence	6 Other (Speci	fv)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not		28b. Time of injury	28c. Injury at work? 1 □ Yes 2 □ No		scribe how inju		
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	1986 Place of Injury At h	ome, farm, street, facto fy)	ory, office	28f. Loc Cit	cation (Street ar y or Town, State	nd Number or Rur e)	al Route Number,
(Check 2 Medical Exam	vsician: To the best of my know niner: On the basis of examinations rse Practioner: To the best of n	on and/or investigation, i	n my opinion, death occurred	at the time	e, date and place	e, and due to the o	ause(s) and manner stated.
29b. Signature and title of certifier	2//2	t mo	9c. License number			ate signed (Month	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Willie Raymond Miller Jr December 2010 12:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Hours 1**X** M 2 □ F 62 Yrs |1*0\mathred{m}27\mathred{m}48* Director 578-66-3402 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mattered and injury or other traumatic event, the Medical Examiner must he mattered and injury or other traumatic event, the Medical Examiner must he mattered as a matter of the matter of the matter of the Medical Examiner must be mattered as a matter of the matter of the Medical Examiner must be mattered as a matter of the matter of the Medical Examiner must be mattered as a matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter of the matter 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 ☐ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20019 U.S.A. 102 58th St SE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc 1 Never Married 2 Married by Yes Specify: Black 1 ☐ Yes 2 X No Specify: If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Self-Employed 10th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Willie Raymond Miller Sr Lillie Freeman 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 904 Jackson Valley Ct, Bowie, MD 2 19a. Informant's Name/Relationship (Type, Print)

Lorenzo L Miller-Son 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Riverdale Park Cre 12/10/2010 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility DL McLaughlin Funeral Home 2019 MLK Jr Ave SE Washington DC 20020 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ata Physicians avvy Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ordenying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) signed by the a g 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by peen 24a, Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy this certificate has performe Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be | Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 1 🗌 Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 24 hours after death Funeral Director: filled in by the

Baltimore, Maryland 21215-0036

within 2

State Registrar

Terri Matin 31. Date filed (Month, Day, Year) DEC 0 8 2010

3

6 Could not be

determined

3001 Hospital Dr., 32. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

1214

20785

29d. Date signed (Month, Day, Year)

2010

City or Town, State)

MD

Medical

29a, Certifie

30. Name a

(Check

only one) 29b. Signa

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

200

Cheverly,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylan		artment <i>tificate</i>			and M		giene Reg. N	4010	40694
	Physicia	n/	Decedent's Name (First, Midd Stella	(e, Last)		Masen			-	ı	2. Date of De	ath	ay 2010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institutio		per)	Tidbei	4b. City, To	wn, or l	Location o		Jecembe		. County of Deat	
-	ZAGITATI		Fox Chase Nurs	ing and Re	hab Hom	ne			Spri	ng			ontgomer	
	Funeral Director		5. Social Security Number 082-05-2679	6. Sex 1 □ M 2 □ ★F	7. Age (In yrs. la 93	st birthday) Yrs.	If Under 1 Months	Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir July 2.	th 7,T9	9. Bird New	thplace (State or Foreign untry) York
	nd now	ŗ	Usual Residence of Decedent 10a. State , 10b. Count	/	10c. City	, Town or Lo	cation							10d. Inside City Limits
	larylar sa-f sl ified	ectc	DC			ningto								1 X Yes 2 □ No
	or 28	Dir	10e. Street and Number				10f. Zip (ode				10g. C	itizen of What Co	ountry?
	s 23a	Funeral Director	560 N St., SW	Apt. #N7	10		20	024					USA	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 □ Never Married 2 ☒ Ma 3 □ Widowed 4 □ Divorce		es? 2 □ No 194	₁ 8-	Was Deceder f Yes, specif I ☐ Yes 2	/ Cuban	, Mexican	jin? (Spec , Puerto R	ify Yes or No- lican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.
21215-0036	hours natur lical E	lete	15. Deced	ent's Education	es.	16a. Deced	fent's Usual	Occupa	tion			16b. l	Kind of Business	
218	iin 72 ie. han "l	dwo	(Specify only high Elementary/Seconday (0-12)	est grade completed) College (1-4	4 or 5+)	life. D	kind of work O NOT use r	done du etired)	uring most	of workin	g		eral Gov	
	d with tygier ther t	Be C	12	1		Secre	etary					L		vermient
lanc	be file fental F rked o tic eve	10 E	17. Father's Name (First, Middle, Frank	•	luzynsk	ci			Ade1		(First, Middle,	Maiden	_	zman
, Maryland	d 2 should be filed within 72 alth and Mental Hygiene. 127 is marked other than "er traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event, the Meder traumatic event event even		19a. Informant's Name/Relation Jesse E. Masen		nd	19b. Mailir 560 I					Route Numbe		r Town, State, Zij 024	o Code)
Baltimore,	ge 1 and to the tit of He in the interpretation of the interpretat	5 0	20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation	n 3 ☐ Removal from S	State Co	lace of Dispo emetery, crer	natory or oth	er place			₹ 2 011	20¢. L	ocation - City or	Town, State
Itim	iit. Pagartmen ortant: njury		4 Donation 5 Other		Arl	Lington							lington,	
Ba	permi Depar Impo any ir		21. Signature of Funeral Service	Kales		61	L60 Ox	on F	ill	Geoi	rge P. Oxon H	Kal Hill	as Funer , MD 207	ral Home,P.A. 745
~.	Physician/		23a. Purt Emer the disease, of shock, or heart failure. List Immediate Cause (Final	only one cause on eac	used the death h line. STAGE			of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death Veal S
	Medical Examiner		disease or condition resulting in death)	Due to (o	r as a consequ	ence of):								
	aaiiiiioi	Jer	Sequentially list conditions,	b. —	LURE TO		VE							6 months
	uted Id ansit	amir	cause. Enter Underlying Cause (Disease or iinjury that initiated events	G	,									
0	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) Last	Due to (o	r as a consequ	ence of):								
3760	ficate g phy: as the		IS SENAN E	_ u										
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours aller death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 🗀 Feta ant at time of d	death 3	Ectopic pro		/				23d. Date of de Month	livery Day Year
0.	at the detach	/ Ph	Part II. Other significant condit	ions contributing to de	ath but not resu	ulting in the u	ınderlying ca	use give	en in Part I		23e. Did t	obacco	use contribute to	the cause of death?
Division of Vital Records, P.O.	requires that the de been signed by the should be detached	ed b	Нурег	tension							1 🗆	Yes 2	. □ No 3 □ P	robably 4xx Unknown
cor	aw req as bee 2 shoi	nplet				_					24a. Was auto	psy	prior to	topsy findings available completion of cause of
Re	Physician: The law rr this certificate has the rall director, page 2 s									_	perfo 1 ☐ Yes	ormed?	death?	s 2 □ No
İta	sician certifi irector) Be	25. Was case referred to medica examiner? 1 ☐ Yes 2XXNo	Hospital:				Other	ce of Deat					
of V	g Physer this eral di	e: To	27, Manner of Death	28a. Date o	npatient 2 finjury	28b. Time of		c. Injury	at A X X Nu		ne 5 🗌 Resid 8d. Describe l		6 Other (Spec	ify)
U	ending seth. or Afte he fun	ficat		tigation	n, Day, Year)	injury	М	work?	res 2□	- 1		Í		
is is	r Atte	Certi	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 28e. Place of	of Injury - At ho g, etc. <i>(Specify)</i>	me, farm, str	eet, factory,	office		2	8f. Location (S City or Tov			ral Route Number,
	To the Hospital or Attending Ph within 24 hours arer decth. To the Funeral Director: After th completed filled in by the funeral	Medical Certificate:	29a. Certifier 1 XXCertifyir	g Physician: To the be	st of my knowle	edge, death	occured at th	e time,	date and p	olace, and	due to the ca	ause(s) a	and manner as sta	ated.
	the Ho hin 24 the Fu nplete	Med	(Check 2 ☐ Medical only one) 3 ☐ Certifyir	Examiner: On the basis g Nurse Practioner: To	s of examination	n and/or inves	tigation, in m	opinior d at the	n, death oc time, date	curred at t	the time, date a	and plac	 e, and due to the 	cause(s) and manner stated.
	Note that the second se		29b. Signature and title of certific	5	~	201	29c. I		number	2			ate signed (Mont)	
			30. Name and address of person	who completed cause	of death (Item	23a) (Type, F	Print)		09605	3		1	2/6/2010	J
1/2	-12		Babette Penr	ay MD 15	245 Sha	ady Gr	ove Rd	. 1	#130	Rock	ville,	Mar	yland 2	20850
	Sta Registra		31. Date filed (Month, Day, Year) DEC 0 8 2010	Beneva 32. Re	gistar's Signat	ure de								

DHMH 17 Rev 7/2009

			For State Registrar		naryianu /	•	tificate of	Death	F	Reg. No.	010	0695
	Physic	ian	1. Decedent's Name (First, Middle, La						2. Date of Dea Month	Day	Year	3. Time of Death
1	/Medi		George Nicho 4a. Facility Name (If not institution, give		rl		Ab City Town o	r Location of Death	December		OLO County of Death	8:22 PM ^M
ी	Exami	ner			,						•	
din	Funeral		Golden Living Ce 5. Social Security Number 6.5		age (In yrs. last bi	irthdav)	if Under 1 Year	stown If Under 24 Hrs.	8. Date of Birt	_ wa ʰ	shingto	on place (State or Foreign
>	Director		215-42-1672 Usual Residence of Decedent	1 Q M 2□F	67	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day April 23	, Year) , 1943	Cou	ntry) land
	aryland show d at	-	10a. State 10b. County		10c. City, Tov	vn or Lo	cation					10d. Inside City Limits 1X Yes 2 ☐ No
	he M 8a-f otifie	Director	MD Washingt 10e. Street and Number	on	Hager	sto						
	with t	급					10f. Zip Code			10g. Citize	en of What Cou	ntry?
	eath 1s 23 must	eral	750 Dual Highwa	Y 12. Was Deceden	t Ever in H.C.	T ₁₂ 1	21740	lianania Oriain? (Ca	osifu Vac ar Na	USA	4. Race - Ameri	icon Indian
036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notifled at	by Funeral	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 1 Yes 2 If Yes, Give Year or Dates	i?] No		f Yes, specify Cuba 1 ☐ Yes 2∑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	, etc.
21215-0036	be filed within 72 hor ntal Hygiene. of other than "natura event, the Medical E	Completed	15. Decedent's E (Specify only highest gr		168	a. Deced (Give	dent's Usual Occup	eation during most of work d)	king	16b. Kind	d of Business/Ir	ndustry
12	within ene. than " he Me	ᇤ	Elementary/Secondary (0-12)	College (1-4o		eac		2)		Educ	ation	
	e filed al Hygiv other vent, ti	ပို	17. Father's Name (First, Middle, Las			<u>eac</u>	TIET	18. Mother's Nam	e (First, Middle,			
Maryland	lid be lental rked o	o Be	Nicholas Mars					Marie G			,	
<u></u>	ges 1 and 2 should b it of Health and Ments If item 27 is marked or other traumatic ev	우	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailir	ng Address (Street	and Number or Rui				in Code)
Ma	nd 2 s Ith ar 27 is 27 is		Catherine Bushey		l l			ew Dr., Ha				
ē	s 1 and 2 f Health item 27 i	-	20a. Method of Disposition	/ 0003111			sition (Name of natory or other place		Date		ation - City or T	
Baltimore,	t. Pa rtmer rtant: njury		1 Burial 2 No Cremation 3 4 Donation 5 Other (Special	ify)	e	ourg	Crematoriu	m 12/10		Smith	sburg,	MD
Ba	Depa Impo any ir		21. Signature of Funeral Service Lice	nsee		- 1						neral Home
lim.			22a Barti Enter the disease or con	antiantians that save	ad the death. Do	3	05 N. Pot	omac St.	, Hagers	stown	MD 21	
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a		hy		Morrison as cardiac		rest,		Approximate Interval Between Onset and Death
	tificate be executed with the purial-transit as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence							
	ath cer attendir for use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		e pf pregnancy 2 □ Fetal deat at time of death		Ectopic pregnancy Other (specify)	4		23	3d. Date of delive	very Day Year
rds, P.O.	w requires that the de been signed by the s should be detached	ठि	Part II. Other significant conditions	contributing to death	but not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did to			the cause of death?
	The la ate has page 2	Completed							24a. Was autop perfo 1 Yes		24b. Were aut prior to co death?	topsy findings available ompletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Place of Deat				
7	si si dir	ပ္	1 Yes 2√2 No	Hospital: 1 ☐ Inpa	tient 2 ER/O	utpatier		41X Nursing Ho	ome 5 Resid	dence 6	□Other (Spec	ify)
ion	Attending Predeath. sctor: After to the funera		27, Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation			Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	now injury	occurred	
Divis	Hospital or Attend 44 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of I	njury - At home, f etc. (Specify)	arm, str	eet, factory, office		28f. Location (S City or Tox		Number or Rui	ral Route Number,
	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier Check only one) Certifying P	hysician: To the bes miner: On the basis and manner:	et of my knowledg of examination a stated.	je, deat nd/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To the I	M	29b. Signature and title of certifier	Jaa j			29c. Licens	e number 28365	5	29d. Date	signed (Month	to the cause(s) 7, Day, Year) 9, D2/740
اك	14+1		30. Name and address of person who	completed/cause of	death (Item 23a)	(Type,	Print) mil	Street	Hage	oter	ur to	102/740
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 13	32. Regis	trar's Signature		horse					· · · · · · · · · · · · · · · · · · ·
DHA	/H 17 Boy 1/2	001		Manager	- 1	14						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of M	larylan		rtment of F		Mental Hy	giene Reg. No.	Y Thomas	10696
ļ			Registrar Decedent's Name (First, Middle, Little Control of the Control						2. Date of De Month	ath	Year	3. Time of Death
*	Physici: /Medic		JOSEPH NELSON MAR			1			DECEMBI	ER 8, 201	.0	6:45 P ^M
397	Examin	er	4a. Facility Name (If not institution, gi GENESIS WALDORF (r)		4b. City, Town, or WALDOF		atn	4c. County of CHARI		
- 1/4	Funeral Director				nge (In yrs. I	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year)	9. Birthpl Count	
èlin	Б		Usual Residence of Decedent 10a. State 10b. County		10c City	/. Town or Lo	cation	1	12223			0d. Inside City Limits
	Maryla f sho	Ď	MARYLAND CHARLE	ES.	1	BURG	34.011					1 X Yes 2 □ No
	th the or 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Coun	try?
	ath wi		12300 CHANNEL COL				20664		/6 - // \	UNITED S		
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show marked other than "natural", are items 23a or 28a-f show marked other the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? 19!	J 1	Vas Decedent of H f Yes, specify Cuba I □ Yes	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		White,	etc.
9	2 hour		15. Decedent's B	 Education		16a. Deced	lent's Usual Occup	ation	and de a	16b. Kind of Bus		
21215-0036	within 72 ene. than "na' he Medic	Completed	(Specify only highest g	College (1-4o	r 5+)		kind of work done OO NOT use retired		vorking	בו בכידסדר	·	OPERATIVE
d 21	filed w Hygiel other tl		8TH GRADE 17. Father's Name (First, Middle, Las	st)		MAC	HINE OPER		ame (First, Middle,			JFEKAIIVE
Maryland	should be and Mental s marked o umatic eve	To Be	JOSEPH NELSON YOU			T			ELIZABET	- 0)		
	nd 2 s Ifth ar 27 Is		19a. Informant's Name/Relationship MARY E. MARSHALL				,		Rural Route Numb NEWBURG,			Code) 0 664
altimore,	0 0		20a. Method of Disposition 1	☐Removal from Stat	e c	emetery, cren	sition (Name of natory or other plac		Date	20c. Location - C		
<u>=</u>	Parint:		4 □ Donation 5 □ Other (Special Street of Funer Justice	eify)	MARY		Name and Addre			CHELIENHAM	i, Mai	RYLAND
Ba	permit. Departn Importa any Inju		LIDIA C. THORNION 23a. Part1. Enter the disease, or conshock, or heart fallure. List only	JOHNSON M	00583	34	<u>39 LIVINO</u>	SSTON RO		AN HEAD,	MAR'	YLAND 20640 Approximate
8760,	Physician / Medical Examiner physician and physician and the prival-transit in the prival-transit.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events receiting in death.) Last	a. Due to (or a b. Due to (or a c.	as a consequence	uence of):	AOMC	CAA	DIOUA!	WLAN	_ 8	CHIZ.
O. Box 6	ath certifi ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3□	Ectopic pregnanc	y		23d. Date Mon		ery Day Year
<u> </u>	uires that the de n signed by the a Id be detached f	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the ur	nderlying cause giv	ren in Part I.	23e. Did 1	obacco use contril		ne cause of death?
Il Records,		Completed							24a. Was auto perfo 1∐ Yes	psy pr prmed? de	/ere auto rior to cor eath? □Yes	psy findings available mpletion of cause of 2 No
Vital	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospîtal:	4:4 O.	ED/Outration	t 3 DOA Oth	or:	Death (Check only			
O.	Attending Physician: r death. ector: After this certific: by the funeral director, i	n: To	27. Manner of Death	1 ☐ Inpa		28b. Time of Injury	1 3 DOX	4 A INUISING	g Home 5 ☐ Resi 28d. Describe	dence 6 ∐Othe how injury occurre		y)
Sior	tendin eath. or: Aff	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on			M 1 □	Yes 2 □ No				
Division or	pital or Attendons after deatheral Director:	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of i building,	njury - At ho etc. <i>(Specif</i>)	ome, farm, str y)	eet, factory, office		28f. Location (City or To	Street and Numbe wn, State)	r or Rura	al Route Number,
	Hos Fur tely	Medical C		Physician: To the besaminer: On the basis and manner:	of examina							
	To the within 2	Me	29b. Signature and title of certifier				29c. Licens	se number	1/6	29d. Date signed		
			1/1/2	5			> 1/	107	67	DECEMBER	9,	2010
a	BD		30. Name and address of person when PHILLIP WISOTSKY	o completed cause of , M.D. 1				R, SUITI	E 207, WA	LDORF. M	ARYL	AND 20602
	Sta Registr		31. Date filed (Month, Day, Year) DEC 10	32. R	strar's Signa	ature	banks	·		,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State of Ma	arylan	d / Depa	artment	t of H	ealth	and M	/lental Hy	gien	ie .	**	0 0 0 7
-	-10		State Registrar				Cer	tificate	of D	eath			Reg. N	No.	IJ	9069/
	Physicia	an/	1. Decedent's Name	(First, Middle, La	ast)							2. Date of De Month		Dav	Year	3. Time of Death
	Medi			Marianne		ne l	Mertz					Novemb	er :	30, 20	010	8:38 P.M
	Exami	ner	4a. Facility Name (if n					4b. City, T	,		of Death		4	1c. County of		
	Funeral		Suburban 5. Social Security Nur			(In vrs la	ast birthday)	B€ If Under	thes	If Under	24 Hrs	8. Date of Bir	+h	Mont	- Di	
	Funeral Director		215-36-44		1 □ M 2 🖾 F		84 Yrs.	Months	Days	Hours	Min.	(Month, Da	Year,	1926	Coun:	flace (State or Foreign try) Germany
	3		Usual Residence of D	ecedent								D-P-U	,	-55		OCTIMALLY
	/land f sho ed at	호	10a. State	10b. County		10c. City	y, Town or Loc	ation							1	0d. Inside City Limits
	Man 28a- lotifie	Director	Maryland	Montgo	omery	R	ockvil.	~								1 🗌 Yes 2 🛣 No
	th the 3a or t be n	<u>a</u>	10e. Street and Numb					10f. Zip (10g. (Citizen of W	hat Coun	try?
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	Funeral	12401 Sain	nt James			lao u		0850		1.0.0	25. 37. 31		nited		
	r dea or ite		11. Marital Status 1 ☐ Never Marrie	d 2 Married	12. Was Decedent E Armed Forces?			Vas Decede Yes, specif	ent of His fy Cuban	panic Ori , Mexicar	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		14. Race Black	 Americ White, e 	
Š	s afte al", c Exam	d by	3 🖾 Widowed 4		1 Yes 2 XII If Yes, Give Year or Dates.	40	1	☐ Yes 2	X No	Specify:				Specify:	Whi	te
č	hour	Completed		15. Decedent's	Education		16a. Decede	ent's Usual	Occupat	tion			16b.	Kind of Bus		
Š	in 72 e. Ban "	ᄩ	(Special Special	rade completed) College (1-4 or 5	+)	(Give ki life. DC	ind of work NOT use i	done du retired)	ıring mos	t of worki	ng				,	
2	/gien			, , , ,	5+	1	Der	ntist						Dent	istr	y
3	tal Hydra even even	To Be	17. Father's Name (Fit	rst, Middle, Last,						18. Moth	er's Name	e (First, Middle,	Maide	n Surname)		
-	y id be lid be narke	-		skar	Maret			-				Emmy	G	erhard	lts	
	partificate, wat yield a first 12-to permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		19a. Informant's Nam									l Route Numbe				
	and 2 Health em 2 ther 1		Wolfgang M		phew	Jook D				ke R		Ashfor				
1	ge 1 i ∓ ii	ĺ	1 🗆 Burial 2 🛭	Cremation 3	Removal from State	C	lace of Dispos emetery, crem	atory or oth	ner place			Date		Location - 0	•	
1 3	it. Pa itmen itmen		4 Donation 5		**	Met	ropoli					/2010				Virginia
Č	Dan permit Depar Impor any ir	-	21. Signature of Fune	O CONTROL LICE) N 0 . () (L	I .					Vol Fur				m 20077
			23a, Part 1, Enter the	e disease, or cor	nplications that caused	the death								rsbur	g, M	D. 20877 Approximate
	Dhusisian/		shock, or heart t Immediate Cause (Fi	failure. List only	one cause on each line.				, 0				,			Interval Between Onset and Death
á	Physician/ Medical	ı	disease or condition resulting in death)		a. Intracra			rhage							-	
	Examiner			4	Duc to (or as a	consequ	crice oij.								4	
2		ner	Sequentially list cond if any, leading to imm cause. Enter Underly	ditions, nediate	b. Due to (or as a	consequ	ence of):								\top	
à	age of the d	ami	Cause (Disease or iin that initiated events	njury	C.										LU.	
38 PM	exec an an	Ě	resulting in death) La	st	Due to (or as a	consequ	ence of):									
80 G	icate be executed physician and sthe burial trapsit	edical Examiner			d		-								4	
	rtifica ling p e as t		IF FEMALE:		000 15	f		- With								
11 30 2010	requires that the death certific been signed by the attending I should be detached for use as	Completed by Physician/M	23b. Was decedent pr in the past 12 mg	onths?	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at	2 🗌 Fetal	Ideath 3 🗌	Ectopic pro						23d. Date Mont		ory Day Year
77	the great	ıysi	1 ☐ Yes 2 🛣 9 ☐ Unknown	No	g Unknown	une or di	eatii 5 🗆	Other (spe	city)							,
30	hat the ed by detac	y P	Part II. Other significa	ant conditions	contributing to death bu	t not resu	ulting in the un	nderlying ca	use give	n in Part	l.	23e. Did to	obacco	use contrib	ute to the	e cause of death?
	Jires t sign Id be	q p	Hypertens:	ion, St	roke, Carot	id S	tenosi	s				1 🗆	Yes 2	2 🔀 No 3	☐ Prob	pably 4 Unknown
-	require been si should	lete										24a. Was	an	24b. W	ere autop	osy findings available
	ne lav e has	omp										autor perfo	rmed?	de	ath?	npletion of cause of
2 -	an: Ti tificat tor, pa	Be C	25. Was case referred	to medical					26. Plac	e of Deat	th (Check	1 \(\text{Yes} \)	2 🔀 1	No. 1	Yes	2
rianne 11	ysicia is cer direc	To B	examiner? 1 ☐ Yes 2 🔀	No	Hospital:	nt 2 🗆 E	ER/Outpatient	3 DOA	Othor			me 5 - Resid	dence	6 C Other	(Specify)	
Marianne	Attending Physician: The law requires that the death certific ardeath. ardeath. ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	<u>ن</u> :	27. Manner of Death	5 D D	28a. Date of injury	/	28b. Time of injury		c. Injury a work?		$\overline{}$	28d. Describe h				
ج ر 2	eath. or; Af	ig	2 Accident	5 Pending Investigation	on		,,	М		es 2 🗆	No					
z, Ma	or Att fter d irect n by t	Certificate:	4 Homicide	6 ☐ Could not determined		y - At hor (Specify)	ne, farm, stree	et, factory,	office		2	28f. Location (S			or Rural i	Route Number,
NC	oital o			7												
エ	Hos 24 ho Fune	Medical	(Check 2 L	J Medical Exan	sician: To the best of niner: On the basis of ex	amination	and/or investig	gation, in m	y opinion	, death oc	curred at	the time, date a	ind plac	e, and due t	o the cau	se(s) and manner stated.
0	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s.	Σ	only one) 3 L 29b. Signature and titl		rse Practioner: To the b	est of my	knowledge, de		ed at the t License r		and place			e(s) and man ate signed (
					. ~	-0	144									
				s of person who	ompleted cause of de	th (Item	23a) (Type, Pri)	65	120			рес	ember	1, A	2010
			/		e, M.D., 86	\/			wn R	load.	Bet	hesda,	Mar	yland	208	14
	Sta	le	31. Date filed (Month,	Day, Year)	32 Registrar									-		
1	Registr	ar	020	07 20		1		Service Market								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jassmine Lashae McNair 1700 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death TENINSULO HICOMICO 910NA If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🖾 F Min (Month, Day, Year) 03 18 1990 Virginia 20 Yrs **Director** 228-59-4140 Usual Residence of Decedent 28a-f shov 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Virginia Beach VA Virginia Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1600 Gelding Court 23453 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Soldier U.S. Army Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edwin McNair Tonya Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Tonya Watts/ Mother 1600 Gelding Court Virginia Beach, Virginia 23453 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State 12-3-2010 Norfolk, VA 4 Donation 5 Other (Specify) Woodlawn Mem. Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fure. List only one-cause on each line. 23a. Part 1. Enter the dis Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Trauma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Motor Vehicle Accident Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events Ж resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f 9 X Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No 1 Inpatient 2 K ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Division car accident 1 ☐ Yes 2 🗷 No 2 Accident 11/26/10 416 Investigation within 24 hours after death

To the Funeral Director: / Single 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pallenger B30 Ocem Hucy Street Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centrol Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) DME H50447 11/27/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Snyder,

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

32. Registrar's Signature

Carroll St. Salsbury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **5**, Month **Physician** Norma Lorraine Mezick 2010 A M December 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Arbor at Baywoods Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Funeral Year) 1 □ M 2 🔀 F Months Days Hours Min. 220-12-1536 87 March 28, Director 1923 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2 📆 📢 o 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 2 Weems Creek Drive 21401 U.S.A. Funeral death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Event Armed Forces?
1 □ Yes 2 ☑ No If Yes, Give Year or Dates: Black, White, etc 72 hours after 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 3 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r within 7 College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Mezick Shellie Noble ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traunonce. Lynne Cronyn/friend 169 Williams Drive Annapolis, Maryland 21401 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State Tyaskin Meth. Church Cem. 12/9/10 Tyaskin, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses Miglini , Kle ber 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Menle VIS. Advance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Year 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ icate has been się , page 2 should b 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy The 2 No 1 □Yes 2 1 No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 ☐ Pending investigation To the Hospital or Attendii
within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lavakoli 2200 000 31. Date filed (Monti

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 DM 2 DF Hours Months Days Min 279-12-6715 93 23/191 Yrs Director Ohio Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes XX No MD Anne Arundel Annapolis 10e. Street and Number 9 10f, Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 2912 Southwater Point 21401 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married TYNYYes 2 If Yes, Give Year or Dates 2 No WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: White Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event event eve Elementary/Seconday (0-12) 4+ 0wner Credit Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Joseph Morris Freemont Ike 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Griffin Daughter Southwater Point Dr. Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 12/7/2010 Glen Burnie, MD 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final et and Death Ph sician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions Examine ii any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) Yes signed by the a Id be detached f 9 Unknown g
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of : After t 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending death. 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Underlical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person (Item 23a) (Type, Print) DEFENSE HWY WHNAPOL 100

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 ALVERT MAGRUDER PM 2010 5106 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNTEL APUNDER MEDICAL CENTER ANNAPOLIS 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**火** M 2 □ F 579-16-9013 Months F&Bnth 1 Day 1 92 2 Mary Yand Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Anne Arundel ShadySide 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20764 USA 4909 Olive Street within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ⚠ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed 3 Divorced 4 Divorced Year or Dates. WWII 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) DC Fire Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Fred Magruder Rose Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Magruder Spouse 4909 Olive Street ShadySide, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/02/2010 Glen Burnie, MD 21. Signature of Fun al Service License 22. Name and Address of Facility 12 Ridgely Annapolis, Aye 21401 Vali Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE WEEKS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Pregnant at time of death Yes 2 No 9 Unknown ate has been signed by page 2 should be detacl Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No မ 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury accurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) 11/30/ 66753 30. Name and address of pers on who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - StateAmended #26 per MD, RG FCHD 12 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death DECEMBER 8, 2010 Physician/ MOSS HAROLD WAYNE 6:04A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 20 9. Birthplace (State or Foreign Country) Maryland 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 213-42-1686 66 **Director** 1944 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Frederick Brunswick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21716 1006 2nd Ave. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, and 2 should be filed within 72 hours after deat Health and Mental Hyglene. Hen 27 is marked other than "natural", or iter then traumatic event, the Medical Examiner. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 ☐ Yes 2 😿 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 1 College (1-4 or 5+) Construction Brick Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Naomi Minnick Earl C. Moss, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 2nd Ave., Brunswick, MD 21716 Glinda Moss / Wife or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/11/2010 Brunswick, Maryland Heights Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21716 t rt 1, Enter the mas, or complications that can led the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failured ist only one cause on ellips. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (o sician and burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Fuherral Director: After this certificate has been signed by the attending physicis treed filled in by the funeral director, page 2 should be detached for use as the burn IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perforn 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Place of Death (Check only one) Be examiner? Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident Dicide 5 Pending injury work? 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital or / within 24 hours after To the Funeral Dire completed filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

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Box (

P.O.

Division of Vital

23a) (Type, Print)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item

- May

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 1207 Timothy Lee Morris 2010 December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 7. Age (In yrs. last birthday) ambide Tche chester If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 63 214-52-0027 1947 Maryland Director Aug. 8, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examines must be required. MD Cambridge Dorchester 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 318 Willis Street 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 No If Yes, Give 1966-70 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) seafood owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Meredith Bryan Morris Ruth Todd 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29522 Corbin Parkway, Easton, MD Brian K. Creighton nephew Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 12/9/10 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner certensio Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the a □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation within 24 hours a er dea h.

To the Funeral Director A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12-7-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (M State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 tage of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - State Registrar Reg. No. 1. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Month 12 ^YPO 41 lene 10 Thnie 11:00aM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rising Sun Cecil 87 Post Rd. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date or Day (Month, Day 20) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Days ^{∕°}1^{′′}93<u>0</u> 223-34-6730 80 Director Apr. VA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Cecil Rising Sun 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 87 Post Rd. 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify. Completed 3 XVidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Shoemaker Shoe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James C. Grubb Dora Sharpe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 Harford View Dr. Port Deposit, MD 21904 Carol Miller/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Hopewell Cemetery 12/14/2010 4 Donation 5 Other (Specify) Port Deposit, MD 21. Signature of Funeral Service Licenses 22 Name and Address of Facility R.T. Foard Funeral Home, P.A. Richard L. Goodie per DVR Queen St. Rising Sun. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Karkinson Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been to completed filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform Yes 2 death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical **Example 1** Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number D00048050

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please *	Type or Print in Bl			•	40 M 1 M	0705
		•	For State Registrar	State of Maryland	/ Department of F Certificate of L			ene (U U a. No.	10/05
	Physicia Medic		1. Decedent's Name (First, Middle, Last) MARY	CATHRYN	NORTON		2. Date of Death	Day Quear	
ز	Examir Funeral Director		4a. Facility Name (if not institution, give s 5707 WALKER 5. Social Security Number 234542972 6. Sex	MILL RD	PRINC	E GEORGE If Under 24 Hrs. Hours Min.	8. Date of Birth (Manth, Day)	9. Bi	th GEOGES Courter thiplace (State or Foreign number) 11 10 w/N, W.V
	e Maryland r 28a-f show notified at	Director	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number			EIGHT	5		10d. Inside City Limits 1. 1 Yes 2 □ No
	a filed within 72 hours after death with the Maryland that hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	5707 WALKER	Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp. n, Mexican, Puerto		g. Citizen of What C U 14. Race - Ame Black, Whit	erican Indian,
21215-0036	72 hours afte n "natural", o ledical Exam	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad		1 Yes 2 6	ation	king 16	Specify:	SLACK Industry
	be filed within antal Hygiene. Ked other than c event, the M	ادها	Elementary/Seconday (0-12) 17. Father's Name (First, Middle, Last)	College (1-4 or 5+)	life. DO NOT use retired)		ne (First, Middle, Ma.		Schools?
	12 should lith and Me 27 is mar	No.	19a. Informant's Name/Relationship (Typ) ANGEUA PI	ACICSON ST PRINT) ALLER PLICER	19b, Mailing Address (Street a	and Number or Rui	ral Route Number, Co PP UPPE		ip Code) BOO NO 207
Baltimore,	t. Pa rtmer rtant rjury		20a. Method of Disposition 1	emoval from State	e of Disposition (Name of etery, crematory or other place AL 1 Cem)	entory 12-	14	ARPERS FE	pryWV
Ä	permi Depar Impo any Ir	7	23a. Part 1. Enter the disease, or compli	cations that caused the death. D			MARY/ANG		WKIRK MU 201 Approximate
	h sician/ Medical Examiner		shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen	CANC	CR		ě	Interval Between Onset and Death
	e be executed ysician and e burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequent	÷ = =				
. Box 68760	of the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bu	· ·	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 W No 9 Unknown	Sc. If yes, outcome of pregnancy 1 Live Birth 2 Fetal dr 4 Pregnant at time of dear 9 Unknown	eath 3 🔲 Ectopic pregnanc	y		23d. Date of de Month	elivery Day Year
ds, P.O	v requires that the dea sbeen signed by the a should be detached f	ا ۾ا	Part II. Other significant conditions con	tributing to death but not resulti	ng in the underlying cause giv	ven in Part I.		2 □ No 3 □ F	o the cause of death? Probably 4 \square Unknown
Division of Vital Records, P.O.	รเตสา: The law ท s certificate has b lirector, page 2 sF	Be Completed	25. Was case referred to medical		26. Pl	ace of Death (Chec		prior to death?	utopsy findings available completion of cause of
n of Vita	or Attending Physician: The la after death. Director: After this certificate ha I in by the funeral director, page	욘	examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER 28a. Date of injury (Month, Day, Year) 28	b. Time of 28c. Injury work	4 ∐ Nursing H ⁄ at	ome 5 Residence 28d. Describe how		cify)
Divisio	ortal or Atter ours after dea oral Director illed in by the	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office		City or Town, S		
:	to the Hospital or f within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2' Medical Examine	ian: To the best of my knowledger: On the basis of examination an Practioner: To the best of my kn	nd/or investigation, in my opinion nowledge, death occurred at the 29c. License	on, death occurred a e time, date and pla e number	at the time, date and pose, and due to the ca	place, and due to the use(s) and manner as I. Date signed <i>(Mont</i>	cause(s) and manner stated. s stated. h, Day, Year)
	6		30. Name and address of person who co	Impleted cause of death (Item 23)	D 00	70102		2-08-	2010
	Stat Registra		9200 BHSIL C 31. Date filed (Month, Day, Year) DEC 0 8 2010	32. Registrar's Signature	NOU LARGE	140	2011	7	

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	tate of Maryland / Dep Ce	ertificate of Death		Reg. No. 0	0706
	Physicia		Decedent's Name (First, Middle, Last) Francis Neula	and		2. Date of Dea Dec 7, 2		3. Time of Death 1:15 A M
	Medic Examin		4a. Facility Name (if not institution, give street 7910 Malcolm Road	and number)	4b. City, Town, or Locatio		4c. County of Dear Prince Geo	
ī	Funeral Director		5. Social Security Number 6. Sex 1 127 M	2 ☐ F 7. Age (In yrs. last birthday 77 Yrs.) If Under 1 Year If Und Months Days Hours	der 24 Hrs. 8. Date of Birt s Min. (Month, Day Feb 26,	9. Bir (, Year) Co 1933 Was	thplace (State or Foreign untry) shington DC
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-1 ootifie	Director	MD Prince Geo	orge's C	Linton			1 Tes 2 XXVo
	n with the is 23a or nust be r	Funeral D	10e. Street and Number 7910 Malcolm	Road	10f. Zip Code 20735		10g. Citizen of What Co United St	
39	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2XX Married 1	Vas Decedent Ever in U.S. Varied Forces? AVes 2 □ No 1953— Yes, Give ear or Dates. 13	. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 Yes 2 No Speci		14. Race - Ame Black, Whit Specify:	
2-0	hours natur	olete	15. Decedent's Education (Specify only highest grade co	on 16a. Dec	edent's Usual Occupation	19	16b. Kind of Business	
121	ithin 72 ene. r than " the Me	Completed		ife.	e kind of work done during me DO NOT use retired) oto Engraver	lost of working	Printing	
nd 2	filed wall Hygi d other	Be	17. Father's Name (First, Middle, Last)			other's Name (First, Middle,		
ryla	uld be d Ment marke natic	ᅌ	Francis C. Neu			Mary Lafon		
Baltimore, Maryland 21215-0036	nd 2 sho ealth and m 27 is i		19a. Informant's Name/Relationship (Type, Pr Esther Neuland (wife)	7910	iling Address (Street and Num D Malcolm Road, C			o Code)
nore	age 1 a ent of H nt: If ite y or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		position (Name of ematory or other place) i11 Cemetery Dec	Date 1/4 2010	20c. Location - City or Suitland, Ma:	
Saltir	permit. P Departm Importar any injur		21. Signature of Funera Survice Licensee		22. Name and Address of Fac	cilityLee Funeral H		
_	ŭ ∩ = 7 7 0 0	9 9	23a. Part 1. Enter the disease, or complication	700003	Ferry Road, Clint		est	Approximate
-	hysician/	6 7	shock, or heart failure. List only one cau Immediate Cause (Final disease or condition	se on each line.	1653			Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as consequence of):	ovoscular	nccident		
	- ±	iner	Sequentially list conditions, b. — in any, leading to immediate cause. Enter Underlying	Due to (or as a consequence oi).	243760101	Keerden		
	xecuted al-trans	Examiner	Cause (Disease or iinjury that initiated events c. — resulting in death) Last	Due to (or as a consequence of):				
200	cate be executed physician and the burial-transit	dical	d	<u> </u>				
687	sertifica nding pl	n/Me	IF FEMALE: 23c. If	yes, outcome of pregnancy			23d. Date of de	livery
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	☐ Live Birth 2 ☐ Fetal death 3 ☐ Pregnant at time of death 5 ☐ Unknown	Sctopic pregnancy Other (specify)		Month	Day Year
s, P.C	ires that I signed b	Completed by P	Part II. Other significant conditions contribu				bacco use contribute to ′es 2 🌠 No 3 □ P	the cause of death?
cord	aw requas beer 2 shou	plete	Hypercoagula			24a, Was a		topsy findings available completion of cause of
Re	sician: The law scriftcate has t		25. Was case referred to medical		00 Plans (D	perfor	med? death?	2 No
Vita	ysicial is certi directo	To Be	examiner? 1 Yes 2 No Hospit	al: 1 Inpatient 2 ER/Outpati	Lou	leath (Check only one) Nursing Home 5 Resid	ence 6 Other (Spec	ifv)
n of	iding Ph th. After th funeral		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	Ba. Date of injury (Month, Day, Year) 28b. Time injury		28d. Describe he	ow injury occurred	
Division of Vital Records,	l or Atten after deat Director: I in by the	Certificate:	3 Suicide 6 Could not be	ie. Place of Injury - At home, farm, s building, etc. (Specify)			treet and Number or Ru n, State)	ral Route Number,
	Hospita 24 hours Funeral sted filled	ledical	(Check 2 Medical Examiner: O	To the best of my knowledge, death n the basis of examination and/or inve	estigation, in my opinion, death	occurred at the time, date ar	nd place, and due to the	cause(s) and manner stated.
	To the within To the comple	Σ∥	only one) 3 Certifying Nurse Practice 29b. Signature and title of certifier	ctioner: To the best of my knowledge	29c. License number	r	29d. Date signed (Month	n, Day, Year)
				way MD	D0058	2999	12/7/3	2010
2	B8+1		30. Name and address of person who comple		tospital D	rive G-06	CLINTON	MD20735
	Stat Registra		31. Date filed <i>(Month, Day, Year)</i>	32. Registrar's Signature	parke			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 William Jefferson Nicholas, Jr. December 12:31 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth
(Month, Day, Year)
April 3, 1930 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Days Min. Hours 1 X M 2 🗆 F California 578-38-9090 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director Yes 2 No Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 20716 15700 Peach Walker Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Spanish & 1 Never Married 2 Married Completed by Maryland 21215-0036 1 X Yes 2 ☐ No Specify: 3 Divorced White Portuguese Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Home Sweet Home al Hygiene. College (154 or 5+) Elementary/Seconday (0-12) Owner/Broker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be file h and Mental h ' is marked ot Hilda Jacqueline Sanchez William Jefferson Nicholas, Sr. t. Page 1 and 2 should be thent of Health and Mertant; If item 27 is marke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15700 Peach Walker Dr., 20716 Bowie, MD F. Sheron Nicholas / Spouse permit. Page 1 and 2 Department of Healt Important; If item 2 any injury or other I Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 12/6/2010 Davidsonville, MD Lakemont Mem. Gards. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Beall Funeral Home Bowie, MD 6512 NW Crain Hwy., or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Part 1. Enter the disease, or co ne cause on each line Onset and Death Immediate Cause (Final -mply sema Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequend of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Examine Due to (or as a consequence of) ending physicia. -ar use as the burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year jo Pregnant at time of death Yes 2 No 9 Unknown ed by tl detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed b should be deta Completed by in tarction 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Hospital or Attending Physician: The law requires Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has , page 2 2 🗌 No 1 🗌 Yes certificate Yes 26. Place of Death (Check only one) **Division of Vital** 25. Was case referred to medical Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 X Natural work? 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier peul Bach, ono 12 01/10 D46052 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Parkway aunaph, MD 2001 Medical Parkway aunaph, MD 31. Date filed (Month 32. Registrar's Signature State Registrar

		for State Registrar	State of Mar		artment of H rtificate of D			ene g. No. 0 0	0708
Physi	cian	1. Decedent's Name (First, Middle, Las		NT.		·	2. Date of Death Month December	7, 2010	3. Time of Death
/Med Exam		C - RALI 4a. Facility Name (If not institution, give		N	4b. City, Town, or	Location of Death	pecember	4c. County of Dea	
		7811 Old Westove	r-Marion Ro	oad		over			omerset
Funera Directo		210-14-9149	ex 7. Age ((In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 27,	^{Year)} 1914 Mai	thplace (State or Foreign punty) Yland
land ow		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
e Mary a-f sh	ctor	Maryland Somerse	t			We	stover		1 □Yes 2 No
th with the 23a or 28	al Director	10e. Street and Number 7811 Old Westove	r-Marion Ro	oad	10f. Zip Code	21871		g. Citizen of What Co USA	
I e., INIAL y IAILIO ZELZIOUOOO S 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 23a-f show other traumatic event, the Medical Examinations bunsitied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:Wo	world	Was Decedent of His If Yes, specify Cubar 1 □Yes 2 No	spanic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
vithin 72 h ene. than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	ırina most of work	ing 10	6b. Kind of Business	
filed v Hygie other l	Be Co	17. Father's Name (First, Middle, Last)			Janitor	18. Mother's Name	e (First, Middle, Ma	_	one Company
uld be Wental Irked o	5 B	Charles Christop	her Nelson			Hattie	May Law	son	
INTELLATION THE SHOULD SHOULD SHIP AND MEN TO ST IS MARKED TRAUMATIC		19a. Informant's Name/Relationship (Julia Figgs (Gua	/1 /		9		,	City or Town, State, .	, ,
permit. Pages 1 and 2 Department of Health 8 Important: If item 27 is		20a. Method of Disposition 1X Burial 2 Cremation 3 C	Removal from State		sition (Name of matory or other place			0c. Location - City or	
nit. Pa artmen ortant:		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fune fat Service Licen	1)	Sunnyrido	ge Memoria	1 Park 12	$\frac{2}{10/10}$	<u>risfield,</u> SONS FUNE	Maryland
	51	1 Hotal Kol	Shaw-Pruitt	30				, MD 21817	
Physiciar	_	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.	e death. Do not ent	er the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Examine			Due to (or as a c	consequence of):					
cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duc to (or as a c	consequence of):					
cate be executed physician and the burial-transit	edical Exa	resulting in death) Last	Due to (or as a c	consequence of):					
ertifica ing ph	Medi	IF FEMALE:					ंगा	TANK S	
the Hospital or Attending Physician: The law requires that the death certificate be executed bin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tis 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
quires that the de n signed by the a	b	Part II. Other significant conditions o	ontributing to death but r	not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	~ /	o the cause of death?
The law require cate has been si page 2 should b	Completed						24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of
sician: The certificate h	Be	25. Was case referred to medical examiner?	Hospital:		Otho	,,	h (Check only one,		
ding Physin. After this of funeral dire	ion: To	1 Yes 2 No 27. Manner of Death 1 Watural 5 Pending	28a. Date of Injury (Month, Day, Y	2 ER/Outpatier 28b. Time of Injury	f 28c. Injury	4 LI Nursing Ho	28d. Describe how	nce 6 Other (Spe v injury occurred	ecify)
To the Hospital or Attendin within 24 hours after death. To the Funeral Director. Af	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, str (Specify)		63 2 1110	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
e Hospita 124 hours e Funera letely fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the best of a niner: On the basis of en and manner state	xamination and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
To th Comp	Me	29b. Signature and title of certifier	= 04	Tup	29c. License	number 4276	29	d. Date signed (Moni	1-1
XCK		30. Name and address of person who	completed cause of deal	th (Item 23a) (Type,	Print) OS fire 1	PC BLX	1733	Soluh,	ND 21862
S Regis	tate trar	31. Date filed (Month, Day, Year) DEC 0 8	2010 32. Registrar's		back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** p ^M 11-24-2010 Reuben St. Aubyn Orelue 9:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 10203 Frank Tippett Road Cheltenham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 6. Sex **Funeral** Days Hours Min. 1 XM 2 □ F 45 12-2-1964 Jamaica Director 227-67-3674 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Weden Exeminar or that the matthest 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Prince George' Cheltenham 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10203 Frank Tippett Road 20623 Jamaica by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 📆 No Specify. Specify: Jamaican 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self-employed contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elbert Orelue Estrianna Johnson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20623 19a. Informant's Name/Relationship (Type. Print) Venita Roebuck Orelue, 10203 Frank Tippett Road Cheltenham, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State 12-03-2010 Suitland, MD Cedar Hill Cemet. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20746 Cedar Hill FH, 4111 PA Ave., Suitland, 11 Sha Ri Leil MO1616 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a Progressive Metastatic Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if one had in a consecutive diagram and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) sbeen signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Atter this certificate has funeral director, page 2 s autopsy 1 □Yes 2 ☑No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1∐Yes 2 🗹 Ño 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Atter this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Nithin 24 hours after death.

To the Funeral Director: Att 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D59942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8926 Woodyard Rd. Ste 101 Clinton, MD 20735 MDDeepnarayan Tiwarri, 31. Date filed (Month, Day, Year DEC 0 7 2010 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Month Johnnie Perchell Jr. 12:00 p Dec 4 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Southern Maryland Hospital Clinton 5. Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
April 14, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 ☐ F Months Days Hours 1918 South Carolina Yrs. 92 <u>578-50-3811</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Washington 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1800 C Street NE 20002 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ♣ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 2 No Specify: African American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Cafeteria Technician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnnie Perchell Sr. Lilly Prince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Perchell - Niece 1800 C Street NE Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■ Buriat 2 □ Cremation 3 □ Removal from State December 2010 16 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Harmony M f Funeral Service Licer Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure with Acidosis Due to (or as a consequence of) Hypotension Due to (or se a nonesquence of): Electrolyte Abnormalities Due to (or as a consequence of) d IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death

h sician/ Medical **Examiner** Examine

as the burial-tran

by Physician/Medical

Completed

Be

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Certificate:

Medical

been signed by the attending physician

should be detached

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending abuse and the control of the control of the certificate has been signed by the attending abuse and the certificate has been signed by the attending abuse the certificate has been signed by the attending abuse the certificate has been signed by the attending abuse the certificate has been signed by the certificate has b

Division of Vital Records, P.O. Box 68760

Department of h Important: If ite any Injury or ot once.

Physician/

Examiner

Funeral

Director

28a-f show

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"natural"

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me

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Baltimore, Maryland 21215-0036

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Sequentially list conditions, Lause (Disease or iinjury that initiated events resulting in death) Last

1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Unknown

23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🕱 Unknown

25. Was case referred to medical examiner? 2 🗷 No 1 Yes 27. Manner of Death

X Natural

29a, Certifier

Hospital: 28a. Date of injury (Month, Day, Year) Investigation

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at

26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

20735

24a. Was an performed

1 ☐ Yes 2 🗓 No

24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Yes

Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

1 ☐ Yes 2 ☐ No

🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29b. Signature 12

5 Pending

29c. License number MD 65329

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

December 6, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surratts Road 7503 Rasheed A Abassi Clinton, Maryland

31. Date filed (Month, Day, Year) DEC 0 9 2010 Registrar

within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12^{Month} Physician/ 08^{Day} SANDRA PARKSTONE 20TO 7:20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 645 KNIGHTS ISLAND ROAD EARLEVILLE CECIL Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign NOV 11, 1953 Months Days Hours Director 222 40 4559 57 Usual Residence of Decedent 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d, Inside City Limits ms 23a or 28a-f s must be notified MD CECIL EARLEVILLE 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 645 KNIGHTS ISLAND ROAD 21919 USA ral", or items? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black, White, etc. 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify WHITE 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>HOMEMAKER</u> HER HOME Be Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EBER RANDOW BETTY ALLEN alth and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS PARKSTONE 645 KNIGHTS ISLAND ROAD, EARLEVILLE, MD 21919 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State DEC 14°. ALL SAINTS CEMETERY WILMINGTON 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service Licensee 19805 22. Name and Address of Facility MEALEY FUNERAL HOMES, PO BOX 2866, WILMINGTON DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) oni Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year sate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate funeral director, page perform 1 ☐ Yes 2 No 2 X No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 9 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) ë 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Certifica Accident Suicide 1 🗆 Yes 2 No after death Director: / d in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Dir

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signatu 29d. Date signed Month Day, Year) ne and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Beth 2010 December 9:15 AM Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick College View Center 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Social Security Number **Funeral** NewWork Aulgarts Pay 6 ear 1946 152-36-1434 1 M 2 X **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland if Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a State Director 1 Yes 2 No Virginia Prince William Catharpin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20143 3706 Sanders Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Executive Secretary US Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be file tment of Health and Mental rtant; If item 27 is marked o jury or other traumatic eve ၉ Levy Marjorie Frank Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3706 Sanders Lane Catharpin, VA 20143 19a. Informant's Name/Relationship (Type, Print) Ernest A. Phillips, Jr/Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or Frederick, MD 21702 12/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home, PA 22. Name and Address of Facility Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, Md 21702 www . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sclesosis-Ph_sician/ tiPle disease or condition | Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No nin 24 hours after death.

The Funeral Director; After this certific ripleted filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 2 No Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2-11-2010 D600 Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Eredeville MD shah 650 Thomas 31. Date filed (Month, Day 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gennarino Francesco Palombi December 5 2010 3:55 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village 19533 Transhire Road Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Hours 80 April Day Year) 930 New York 059-22-5918 Director Usual Residence of Decedent or 28a-f show 10a, State 10b. County Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Montgomery Village 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 19533 Transhire Road 20886 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. "natural", or δ 1 Never Married 2 X Married Yes 2 X No 72 hours after 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) I.B.M. Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit, Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked Frank Palombi Immaculata Penna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19533 Transhire Road Montgomery Village MD 20886 Dora M. Palombi (Spouse) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) December 10 All Souls Cemetery Germantown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 Months Physician/ Metastatic Carcinoma of Unknown Primary disease or condition) Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 1 Yes 2 L 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 P.O. Records, Hospital or Attending Physician: The **Division of Vital** s after death.

Director: Af d in by the fu filled in by To the Hosp within 24 hou To the Fune completed fil

Baltimore, Maryland 21215-0036

29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D23308 December 6, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Victor M. Priego M.D. 6420 Rockledge Dr. Suite#4100 Bethesda, MD 20817

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2010 19:03 JAMES EARL PADDY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL 2213 SHORE DRIVE **EDGEWATER** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-44-9663 1 **X** M 2 □ F Months Days Hours 06/26/1944 Maryland Director Usual Residence of Decedent or 28a-f shov notified at show 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? è item 27 is marked other than "natural", or items 23a or other traumatic event, the Me it al Examiner must be Funeral United States 21037 2213 Shore Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced ò Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tree Service Tree Trimmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Compton Robert Paddy Myrtle Estep permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Bayard Road, Lothian, Maryland 20711 Lorraine Hall/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/08/2010 Annapolis, Maryland 4 Donation 5 Other (Specify) Hillcrest Cemeterv 22. Name and Address of Facility George P. Kalas Funeral Nome 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Acuk Physician. MYOCARDIAR INFARCTION disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner pertensive Cardiovascular disease use as the burial-transi signed by the attending physician and Physician/Medical Hypertension To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Insulan dependent deabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 ☐ Yes 2 🕅 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ∐ Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending iniury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 M Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 00042752 DECEMBER 06,2010 ne and address of person who completed cause of death (Item 23a) (Type, Print) unapolis MD 2/40/ State 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day PERKINS Year **Physician** 13:40 PM KLIZABETH 12 2010 ГΟ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAMBRIDGE DORCHES TER CENERAL 4657ITAL DORCHESTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year). NOV. 26,1725 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🕏 F Months Days 3-22-9050 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with tha Marylar nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Jorchester enna 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 460 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black δ 3 ₩idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWn 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blake Thompson ပ္ orneli nnie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rris Street Vienna Maryland 21869 James Perkin or other permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other Otice. 20a. Method of Disposition Date 20c. Logation - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ssroads Cemetery 12/11/10 4 ☐ Donation 5 ☐ Other (Specify) Vienna, MD. 22. Name and Address Facility Home, P.A. Henry Funeral Home, P.A. 510 Washington St. Can 21. Signature of Funeral Service Licensee Cambridge MD. 21613 washington sti Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** lobe OWER Pheumonio disease or condition resulting in death) /Medical Due to (or as a continuence of) Examiner UKINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) has been signed by the e 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ AUTOIMMUNE HEPATITIS. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed END STAGE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26 Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 № Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar one)

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

Jeevan Errabolu, M.D.

DEC 09 2010

503 Byrn Street

29c. License number

D69234

Cambridge, MD

29d. Date signed (Month, Day, Year)

21613

200

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZJEEVAN ERRABOLU

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARTHA V. QUILLEN 10:13 AM Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death HOS JSBUR PICE at the ICOM Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 🗆 M 2 🗹 Days 217-28-2814 79 Director 05 - 04 - 1931Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner m ist be notified at Director MD. Somerset Princess Anne 1 🗌 Yes 2 🖫 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21853 U.S.A. 30669 Polks Road 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by permit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Poultry Industry Poultry Grower Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Albert Fooks Beatrice Hammond Fooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code) 30683 Polks Road, Princess Anne MD. 21853 Daughter Judy Quillen 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Beechwood Cemetery 12-07-2010 Princess Anne, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD. 21853 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between nediate Cause (Final Onset and Death Physician/ MULTIPE MYRLOW ease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 10 Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on Signature and title of certifier 29c. License number 10057416 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huiton with 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harold Thomas 0330 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Reg. Med. Center Cumberland Allegany Social Security Number Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Months Sept. Day 219-54-1968 1 X M 2 □ F 60 Hours Min. **Director** 1950 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Westernport 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 405 Poplar St. 21562 United States Was Decedent ______ Armed Forces? 1 X Yes 2 _ No "Yes Give Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 K No Specify. "natural", 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Manufacturer Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harold P. Raines Westfall Mildred 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Raines/ wife 405 Poplar St, Westernport, Maryland 21562 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 K Cremation 3 Removal from State 12/13/2010 Cumberland Maryland Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home J.W. 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) use as the burlal-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No signed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Kegpiratory To the Hospital or Attending Physician: re law equire within 42 hours after death. To the Funeral Director, After this certific-te has been signompleted filled in by the funeral director, age 2 should be completed filled in by the funeral director, age 2 should be a should be a second the funeral director. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown chun cladny 24b. Were autopsy findings available prior to completion of cause of death? Anasarea 24a. Was an autopsy & britmative performed 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical examiner?

1 Yes 2 Ao **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 12/12/10 071244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland 31. Date filed (Month, Day, Year) State 32. Regist ar's Signature 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6;37pm^M Mary Alice Romeo December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Cheverly Prince Georges Hospital Center If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Days Hours Min. (Month, Day, Yea 03/03/191 Director 99 Alabama 577 66 1496 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Upper Marlboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 10906 White House Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0. 1 Never Married 2 Married 1 ☐ Yes 2 K No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 INo Specify: Black should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Specify: 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Day Care Provider Private Childcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Minnie Durden George Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10906~White~House~Rd.,~Upper~Marlboro,~MD20774 Geraldine Griffin Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State maryland National 12/10/2010 Laurel, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility John T. Rhines Funeral Home LLC 3005 12th St., NE Washington, DC 20017 that offused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Part 1. Enter the disease, or complications that coused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ P disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death the 1 ☐ Yes 2 ☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Jas Hospital or Attending Physician; The L24 hours after death.
Funeral Director: After this certificate heted filled in by the funeral director, page 1 🗌 <u>Yes</u> 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗘 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pendina Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year, Or 0, 8, 2010)

Box 68760

P.O.

Records,

Division of Vital

HOSDITA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2 Ž810 6:23 P M Catherine Elizabeth Ritchey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death **Allegany** WMHS Frostburg Nursing & Rehab. Cente Frostburg 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth Funeral 1 M 2 K 02nth 8 1934 Director 214-30-7586 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No Allegany Frostburg 10e, Street and Number items 23a or 10f Zip Code 10g. Citizen of What Country? Funeral 127S Water Street U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygler Important: If item 27 is marked other 1 any injury or other traumatic event, th 10 Custodian Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Machick Preston Marv Susan Ouinn Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4026 Green Gables Drive Ridgeley WV 26**7**53 Robyn Hamilton daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Mem Park 12-21-2010 FRostburg, MD 22. Name and Address of Facility Sowers Funeral Home. P.A. 60 W. Frostburg MD 21532 Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day signed by the a Part II. **Other significant conditions** contrib**y**ting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 24 hours after deatn.
E Funeral Director: After this certificate because filled in by the funeral director, pag 2 No 2 X 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 \square Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhamma, 31. Date filed (Month, Day, Year)

10d. Inside City Limits

Onset and Death

29d. Date signed (Month, Day, Year)

W

1 ☐ Yes 2 No

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifig

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Thomas Johnson

DEC 1 4 2010

0,5333

311 N. Fourth St., Oakland, MD 21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ Day 2010 Alvin J. Schlabach 1:30 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Swanton <u>3488 Bittinger Road</u> . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Ohio 1 M 2 □ F (Month, Day, Months Days Hours Min. **Director** <u>278-24-7848</u> Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Garrett Swanton 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3488 Bittinger Road 21561 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian. Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates and Mental Hygiene.

s marked other than "natura
umatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) farming farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Miller John Schlabach t. Page 1 and 2 should b tment of Health and Mei tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3488 Bittinger Road, Swanton, MD 21561 Celesta Miller-daughter permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other troone. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other placel 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Oakland MD Slabaugh Cemetery 12/14/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. . Signature Puneral Service License 21 N. 2nd St, Oakland, MD 21550 23a. Part . Enter the disease, or complications that causes shock, or heart failure. List only one cause on each line. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 11 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work r death Investigation 2 No 2 Accident within 24 hours after deatl To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29c. License number ٥ 29d. Date signed (Month, Day, Year) 0123 3

Registrar

State

4th St #2, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Johnson, MD, 311 N.

2. Regis rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 21 per fh,g910,12/27/2010dhb Certificate of Death State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 10 Sondra Kay Stephens 2010 10:47p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Havre de Grace Harford Memorial Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Oct. 20 1943 217-40-5843 67 Yrs Director MD Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Conowingo MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21918 USA 44 Christie Hall Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Postal Worker Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louise Wright Harry Francis Moyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Christie hall Rd. Conowingo, MD 21918 Keith R. Stephens/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12/14/2010 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) R.T. Foard Funeral Home, P.A. Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses Name and Address of Facility
LT. Foard Funeral Home, P.A.
LT. S. Queen St. Rising Sun, per DVR Richard L. Goodie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₹hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events executed Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?

1 Yes 2 No Month 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No X No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 X 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Lonaurgo MD 21918

Rowlindsville Rd

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 ear December 6:50p M Carrie B. Stewart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🖺 F Days Hours 0972471921 Virginia Yrs Director 223 40 8989 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 Yes 2 ☐ No DC Washington ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a United States 440 Newton Street, NW 20010 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th Domestic Engineer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sarah Brooks Bernard Tansimore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

District Heights. MD 20747 19a. Informant's Name/Relationship (Type, Print) 7138 Marbury Ct., District Heights, MD Gloria S. Taylor Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State George Washington Cem 12/13/2010 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home LLC 21. Signature of Funeral Service Licensee 3005 12th St., NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this din by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No □ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific

CR T

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER Dorothy Luray Shupp TÖ 2010 12:00P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeder's Memorial Home Washington Boonsboro 7. Age (In yrs. last birthday) 87 yrs. if Under 1 Year If Under 24 Hrs. Social Security Number 215-20-8374 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1-28-1923 MD (**Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director Boonsboro City, Town or Location MD Washington 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? U.S.A. 10f. Zip Code Funeral 21713 141 S. Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Specify: White Completed by 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th grade residence College (1-4 or 5+) Homemaker Be Maryland 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle Trumpower 17. Father's Name (First, Middle, Last) ပ Trumpower Francis Ridenour Snyder 19a. Informant's Name/Relationship (Type, Print)
Deanna J. Mullendore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11228 Dam #5 Rd.Clear Spring, MD 21722 daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Paul Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Dec. 14, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Clear Spring, MD 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc aitle P.O.BOX 310 Clear Spring, MD 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) aceel de Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). Hospital or Attending Physician; The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the bural-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

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DR. ROBERT GUEDENET, 21 WYAND DRIVE, KEEDYSVILLE, MARYLAND 21756 301-432-2222

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1)325/8

12/10/10

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2016 23:13 PM MARY ELLEN SALISBURY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL UNION HOSPITAL OF CECIL COUNTY ELKTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF oCT. 5, 1923 Months Days Hours Min. PENNSYLVANIA Director 87 192-12-5832 Usual Residence of Decedent ral", or items 23a or 28a-f show Ex-miner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND CECIL ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 UNITED STATES 1 PRICE DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes XX No Specify: If Yes, Give Year or Dates "natural", 3XXWidowed 4 ☐ Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EDNA M. SHOALS WILLIAM H. MANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $39\ MANSION\ DRIVE$, NORTH EAST, MARYLAND 21901JAMES C. SALISBURY, JR. / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date BECEMBER 2010 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) NEWARK, DELAWARE MAYERDALE CREMATORY 22. Name and Address of Facility CROUCH FUNERAL HOME 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. PNEWMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examine RAILURE HEAMT CONGESTIVE Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Exami ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed C HOWNIC OBSTRUTIVE that initiated events resulting in death) Last Due to (or as a consequence of) After this certificate has been signed by the attending physician uneral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending hours after death Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P.V. Nonge 1) 10065733 12/06/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smeet , ELKTON, MD -21921 RAO V. PULA NARMYANA 14611 126 A Ear 31. Date filed (Month Day, Year) **2010**

DHMH 17 Rev 7/2009

State

Registrar

Back

Registrar's Signature

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	Medic Examin		Vivian Dawn Sheridan 4a. Facility Name (if not institution, give street and number)	7)	4b. City. Town.	or Location of Deat			County of Death	10:13p™	
	LAGIIIII		595 Grove Neck Rd.		Earlev			Cecil			
	Funeral		5. Social Security Number 6. Sex 7. /	Age (In yrs. last birthday) If Under 1 Year Months Days		8. Date of Bi	rth ay, Year)	g. Birthpl: Countr	ace (State or Foreign	
5	Director		Usual Residence of Decedent	77 Yrs.			Jan. I	1933	3	" DE	
7	land show	Funeral Director	10a. State 10b. County	10c. City, Town or L	ocation				10	d. Inside City Limits	
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7	eath w		595 Grove Neck Rd. 11. Marital Status 12. Was Deceder	nt Ever in U.S. 13	. Was Decedent of	Hispanic Origin? (S	pecify Yes or No		14. Race - America	n Indian.	
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7 2	d Mer mark matic	_	Bruce Cole 19a. Informant's Name/Relationship (Type, Print)	Laure		Ocille					
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re,	1 and of Hea fitem		20a. Method of Disposition	20b. Place of Disp		1	15/2010		ocation - City or Tow	n, State	
<u> </u>	Page ment ant: It ury or		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	R.T. Foar					ing Sun,	MD	
\langle i i i i i i i i i i	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur eral Service Insee		22 Name and Addr R.T. Foa	ess of Eacility rd Funera	1 Home,	P.A.	•		
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Ö	pital or At ours after o eral Direct		29a. Certifier 1 rtifying Physician: To the best	of my knowledge, death	accured at the time	o data and place	and due to the e	21120(a) an	d manner as atated	-	
	e Hos 124 h e Fun eleted	Medical	(Check 2 Medical Examiner: On the basis of only one)	f examination and/or inve	stigation, in my opin	ion, death occurred	at the time, date	and place,	and due to the caus	e(s) and manner stated.	
	To the Hospital within 24 hours a To the Funeral C completed filled	~	29b. Signature and vitle of certifier			se number			e signed (Month, Da		
					Do	05644	19	12	43/10		
	7		30. Manie and address of person who completed cause of	death (Item 23a) (Type,	N. Brix	1 =====================================	tzrde	1/20	Flkton	MD 2192	
	Stat	е	31. Date filed Month, Day, Year 10 32. Regis	trar's Signature		gev.	VY	000	0,000	V [00]	
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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Prince Philip Drive, Olney, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0223 AM ecember 13, 2010 **Physician** Standridge Barbara /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** hestertown IVEr HOS Dital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | Nov. | 10, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex . 1940 **Funeral** 1 ☐ M 2 🔀 F Maryland 214-36-7221 70 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show be filed within 72 hours after death with the Maryla ntal Hygiene.
ed other than "natural", or items 23a or 28a-f show event, I'm Madical Evander and the more revent, I'm Madical Evander. 1 XYes 2 No Director Chestertown MD Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Morgnec Rd. 21620 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Branch Manager Banking 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other i any Injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Williamson LeCompte Ethel Lee Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Morgnec Rd. Apt F 104 Chestertown, MD. 21620 Melvin O. Standridge (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Wesley Chapel Cemetery 12/16/10 Rock Hall, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sérvice Lic 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or or didition resulting in leath) Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ٥ in the past 12 months? 1 ☐ Yes 2 ☐ No ned by the a 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐Yes 2 ☐ No 2.XNo 1 ☐ Yes To the Hospital or Attending PhysIcian: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KDR JACKS 100 BROWN STRUST CHESTER TOWN MAYEND

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 CARROLL Dec. SLADE PM LEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4200 Federal Hill Road Harford Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 **X** M 2 □ F Months Days Hours Min. 218-28-0361 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD. 1 🗌 Yes 2 💹 No Harford Street 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a Funeral 4200 Federal Hill Road 21154 United States Let 15-0036

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Let 1 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service Technician Sears Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph Franklin Slade Gency M. McGrady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21154 19a. Informant's Name/Relationship (Type, Print) (Wife) Helen M. Slade 4200 Federal Hill Rd. Street, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Dec Date 21. 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gar. Fallston, Maryland 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ o (or as a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impuly that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last nding physician use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Yes 2 No. 1 L Yes 2 L 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Fibrillation, Diahetes Mellitus, Syndrone 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? inapropriate Ant: Dintetic Hormone anemia of chronic 24a. Waş an autopsy illnes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural Accident Suicide 2 🗌 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State, Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059387 12/20/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 203 Drive torest Hill mo 019046 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STOTTLEMYER GERTRUDE :10P M DECEMBER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 9. Birthplace (State or Foreign . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days July II, 1926 Czechoslovakia 1 🗆 M 2 🗓 F Months Hours Min. 84 **Director** 514-28-4347 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Tes 2 No Maryland Frederick Myersville 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21773 12348 Wolfsville Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Examiner Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Page 1 and 2 should be filed within 72 hours afte ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Publishing Company Dark Room Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Veralyn Maria Lubavitch Rudo1ph Roehrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence I. Queen/husband 12348 Wolfsville Road, Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mark's Lutheran 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot I X Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 20, 2010 Wolfsville, Maryland Tother (Specify) 21. Six nature of Fus 22. Name and Address of Facility 504 Main Street icen e Myersville, MD Ricketts Funeral Home or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the diseas Approximate Interval Between List only one cause on each line. Onget and eath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by No 3 Probably 4 Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 Tes Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ည 1 Inpatient 2 KER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury Natural 5 Pending 1 Natural 2 Accident 1 Yes 2 No Investigation 6 Could not be ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or in a Certifying Nurse Practioner: To the best of my knowledge ation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ath occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 9c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, mD 21701 Kaufmann 300 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11-25-2010 Gary Sweatt 17:25 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Min. Months Days Hours Director 579-72-0200 58 Washington, DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If time 27 is and Mertal Hyglene Important: If time 27 is and ded other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Temple Hills Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2215 Jameson St. 20748 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Breaker Co. Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Jean Washington John Sweatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2215 Jameson St. Temple Hills Maryland 20748 Shelvie Ross (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12/03/2010 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility.H. Bacon Funeral Home, 21. Signature of Funeral Service Licensee 3447 14th St. n.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscientic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Diabeley marriath Due to (or as a consequence of) resulting in death) Last Physician: The law requires that the death certificate be ex-Physician/Medical Box 68760 the t attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Year Pregnant at time of death Day 9 Unknown a Hinknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 40 page 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 Yes |2 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending after death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29c. License number K. Matyron MD D50689 2512010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN 1L に MAHAココールのカー Sounern Mary Hosgital center 7503 Clinton MD Surraties Road 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Division of Vital

1			For		aryland	l / Dep	artment of H	lealth and	Mental Hy	giene			
	Dhysisis	· · · /	1. Decedent's Name (First, Middle, L	.ast)			rtificate of L	<i>Death</i>	2. Date of Dea			3. Time of Death	
10	Physicia Medi	cal	4a Facility Name (if not institution of	Herbert S.	Stei	n	4b. City, Town, o	- Lauretian of Dan	December		Ž, 2010	11:45ам	
Securit	Examir	ner	4a. Facility Name (if not institution, give street and number) Hebrew Home of Greater Washir			on	4b. City, Town, o	Rockvil		4c. County of Death Montgomery			
	Funeral Director				e (In yrs. las 82		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt	th y, Year)	O Diet	hplace (State or Foreign Intry) Maryland	
		_	Usual Residence of Decedent 10a, State 10b, County			Town or l			INDICE E		7201	10d. Inside City Limits	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director					10c. City, Town or Location Bethesda					1 ☐ Yes 2 🗓 No	
			10e. Street and Number 10f. Zip Code 10g. C						10g. Ci	tizen of What Co			
	tems	Fune	7420 Westlake 7	12. Was Decedent E		13.	Was Decedent of H	20817 ispanic Origin? (S	Specify Yes or No-	Т	14. Race - Amer	I.S.A.	
Maryland 21215-0036	rs after de rral", or its Examine	<u>چ</u>	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Never Married 2 M Married 3 Widowed 4 Divorced Armed Forces? 1 Yes, 2 N No If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexicar 1 ☐ Yes 2 【☑ No Specify:			to Rican, etc.)		Black, White, etc. Specify: White		
15-(72 hou n "natu ledica	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup kind of work done o	ation during most of wo	orking	16b. K	Kind of Business I	Industry	
212	within giene.		Elementary/Seconday (0-12)	College (1-4 or 5	i+)	IITE. L	00 NOT use retired) Sal	Lesman			Rea	tail	
pu	e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Las					18. Mother's Na	ame (First, Middle,		•		
Z S	d Meni marke	-	19a. Informant's Name/Relationship	Paul Stein		19h Maili	40h Marilian Adalasa (Ottoritania)		ROSE SELTZET or Rural Route Number, City or Town, State,			Codel	
	nd 2 sh ealth a n 27 Is ier trau		Corinne Stein -				Westlake					· ·	
Baltimore,	ige 1 an nt of H t: If iten / or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	Removal from State	cer	metery, crei	osition (Name of matory or other place	e)	Date		ocation - City or		
altin	permit. Pe Departme Importan any injury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice		King		d Mem Gro 2. Name and Addres					rcn, va 2 Home, Inc.	
m)		10.00	> Clas	"Damel	2	11	800 New 1	Hampshir	e Ave.,	Silv		ng, MD 20904	
v.	Pnysician/		23a. Part 1. Enter the disease, or shock, or heart failure. List only Immediate Cause (Final	mplications that caused one cause on each line					c or respiratory arr	rest,		Approximate Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a		nce of):	UMON		. 0 . 1	. ,			
27	Lxammer	ier	Sequentially list curditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):										
E	cuted nd ransit	Examiner	Cause (Disease or linjury that initiated events	c									
d'a	be executed sician and burial-transit	cal E	resulting in death) Last	Due to (or as a	a conseque	nce of):							
## 8760	certificate nding phys use as the		IF FEMALE:	d						$\overline{}$			
N F Box 6	death ne atte ed for	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal o	PEtal death 3 Ectopic pregnancy						23d. Date of delivery Month Day Year	
10°		by Pr	Part II. Other significant conditions	-		ting in the (underlying cause giv	ven in Part I.	23e. Did to	obacco u	use contribute to	the cause of death?	
Jrds,	require been signal	eted	MITTER	TENS10 NFARCT	N	001	11 71	CEACE	1 0	•	/ `	obably 4 Unknown	
Reco	The law ate has l	Completed by	1014211-1	NTARCI		KITI	N .01	> 01120	autor		prior to death?	opsy findings available completion of cause of	
ital	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Che	eck only one)				
of V		e: To	1 Inpatient 2 ER/Outpatient 3 DOA Variable From 1 Inpatient 2 Injury at 28d Describe bow injury accounted							fy)			
ion	eath. or: Afte the fun	al Certificate:	2 Accident Investigat	11 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M 1 Yes 2 No									
\mathcal{ST} Division of Vital Records,	ital or Att irs after d 'al Direct led in by		3 Usuicide 4 Under Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							al Route Number,			
	the Hosp nin 24 hou the Fune upleted fil	Medical	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying N	n, death occurred	and due to the car at the time, date a lace, and due to the	nd place	and due to the c	ause(s) and manner stated.					
	Note of the second		29b. Signature and title of certifier	Saewr	wo		29c. License				te signed (Month) CEMBE		
			30. Name and address of person who DINESH D.	PATEL, M	eath (Item 2	(3a) (Type, I	MON T	ROSE F	D, Ro	CK	VILLE	4020852	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ır's Signatu	re &	w		/		/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Saleh Shahriar 2010 \mathbf{P}^{M} December 7:17 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 19715 Boxberry Drive Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours 1 ₹ M 2 🗆 F Director 577-70-1195 62 1948 une Iran Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Gaithersburg Maryland Montgomery 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 20879 19715 Boxberry Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Chief Director
of Capital Projects Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) National Institutes Elementary/Seconday (0-12) College (1-4 or 5+) 5+ of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Enayat Saleh Forougholmolook Tahmasebi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Afsaneh Ziaee Saleh (Spouse) 19715 Boxberry Drive, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 6, Metropolitan 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2010 Crematory 22. Name and Address of Facility DeVol Funeral Home, . Signature of Funeral Savice Licensee 10 East Deer Park Drive, Gaithersburg, MD 20877 M00689 Part 1/Junier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek of fearly failure. List only one cause on each line. Immediate Cause (Final Immediate Ph sician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine by the attending physician and some as the burial-transit Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month ☐ Pregnant at time of death
☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy After this certificate 1 Yes 2 No Yes 2 XN To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the vithin 2 Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D18726 December 6, 2010 10

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Arthur Schoengold, M.D., 18111 Prince Philip Dr., T-10, Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Daniel John Stelzer ecember 8:07 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Wisconsin . Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 X M 2 □ F Days 556-58-9672 69 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6502 Wrangell Rd. 20720 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify: Year or DatesVietnam White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Transit Engineer Transit Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel W. Stelzer Beatrice Walesh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna S. Stelzer / Spouse 6502 Wrangell Rd., Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 12/5/2010 Adelphi, MD 21. Signature of Euneral Sar loc Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy.. Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. Liet only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hheroscherota Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner that heading to in media cause. Enter Underlying Cause (Disease or iinjury Trust of it as a proper manner of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown been signed by a should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? vascular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed Hypertension 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Matural 5 Pending n 24 hours after death.

Reference Birector: A sileted filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Qertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROYCE & BUKNS 14. S. 8118 (TOOD) LNCK & D. I SINGAL MIN

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David Eugene TETER December 10, 2010 8:25ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington 16612 Johnson Drive Williamsport 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 13, 1937 1 🔀 M 2 🗆 F 218-30-7678 73 Yrs Pennsylvania Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Williamsport 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16612 Johnson Drive 21795 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>\$</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 77. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) sales and marketing supply company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Lester Teter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Teter - wife 16612 Johnson Drive, Williamsport, Maryland 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Cedar Lawn Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State Date December 2010 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home latel Helens 415 East Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Deat Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Bledole disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of,: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 \square Pending work? 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day John Henry Thrower 14:25P M December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton . Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) (Month, Day, eb. 21 1 M M 2 □ F Days Hours Months Min. Director 34 32 3316 68 Feb. New Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Clinton MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9708 Hale Dr. 20735 USA 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: Black 3X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver 11th Private permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygies Important: If item 27 is marked other 1 any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bradley Thrower Mamie Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2827 Hilliard Rd. #E Henrico, VA Tyrone W. Thrower/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Dakwood Cemetery 12/11/2010 Richmond, VA . Signature of Funeral Service Liger 22. Name and Address of Facility Briscoe-Tonic Funeral MD 20601 Old Washington Rd. Waldorf Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final fic Ph_sician/ Small Cell Calcinona 54 a disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ated filled in by the Inneral director, page 2 should be detached for use as the burial-transit lied in by the Inneral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day 4 ☐ Pregnam
9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 2 00 Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completed filled Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 1225 CLARA EDNA TAYLOR 12 37 - 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TALBOT MEMORIAL HOSPITAL @ EASTON CASPON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/08/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Months Days Hours 1 ☐ M 2 🛣 F 91 MD 216-10-3566 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Yes 2 □ No EASTON MD TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 610 NORTH WASHINGTON STREET 21601 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SAFETY CROSSING GUARD 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES EDWARD DEAN CLARA BREEDING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 217 PROSPECT AVE., EASTON, MD DIANE TAYLOR PYPER/DAUGHTER 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 12/11/2010 EASTON, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days +CN+5 1101110 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, in the land in immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Stenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes edical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred ending

Examiner Box 68760. P.0. Division of Vital Records,

or Attending Physician; The law requires that the death certificate be executed burial-trar aftending physician for use as the burial s been signed by the should be detached After this certificate has funeral director, page 2 s within 24 hours after death.

To the Funeral Director; A completely filled in by the fu To the Hospital

Physician

/Medical

Examiner

Director

Funeral

<u>8</u>

Completed

Be ပို

Examiner

Physician/Medical

<u>ک</u>

Completed

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Certification: To

Medical

State

Registrar

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Worldon Event in the motified at

Department of Health Important: If item 27 any injury or other tronce.

Physician

/Medical

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 Ayeon

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

25.	. Was case referre examiner? 1 ☐ Yes 2 💢 N	
27.	Manner of Death Natural Accident	5□P

3 Suicide

29a. Certifier

4 ☐ Homicide

investigation

6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Easton

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) and manner stated. J. Shanahan, DC 29b. Signature and title of certifier Timothy

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

52 9 IdRM 31. Date filed (Month, Day, Year) DEC 0 8 2010

RVE 32. Registrar's Signature

TLS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month D. Trettin Gene 2010 P M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arnold Anne Arundel 623 Breton Place If Under 1 Year 8. Date of Birth
(Month, Day, Year)
Nov. 20,1925 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 D F Maryland 217-20-1127 85 Director Usual Residence of Decedent if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "notice".

In any injury or other trainment. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Severna Park Anne Arundel MD 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 **USA** 156 Boone Trail 12. Was Decedent Ever in U.S. Armed Forces? 1946-1 X Yes $2 \square$ No 1950 If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Ear/Nose/Throat Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Naomi Klingbel Clarence Trettin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Penoyar / Daughter 623 Breton Place Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 2010 1 ☐ Burlal 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. Baltimore, MD Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1 Enter be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 010-41 Physician/ iscaso YEWS Medical resulting in death) Due to (or as a consequence of) Examiner 104/3 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ending physician a use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ģ Day Pregnant at time of death Year detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de Completed by The law requires 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No N. To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter Home Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\vec{\sum}\) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending 2 No within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D5181

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

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egistrar's Signature

site 241 Annuni

21401

MD

of person who completed cause of death (Item 23a) (Type, Print)

Ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 9, 2010 Physician/ 7:55 a. M Timko Myles Walter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Nursing Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 12/19/1914 1 ₺ M 2 □ F Maryland 213-09-8463 Director 95 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No California Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20619 23140 Cobblestone Lane permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Fire Department 12 Firefighter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Apperson Sarah Steven Timko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23140 Cobblestone Lane, California, MD 20619 Betty SanAntonio/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Brentwood, MD 12/13/2010 Fort Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licenses Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Aspiration Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed Parkinsons Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for Unknown 9 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: s after death.

I Director; After t 1. Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death oncurred at the time, date and place, and due to the within 2 To the 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8) pms Annopolis William Dr. HIR Tidouster 31. Date filed (Month, Day, Year) 32. Revistra - Signature State Registrar

sician and burial-transit that the death certificate be executed physician the burial Box 68760 e attending pl detached P.O. Records, has Division of Vital or Attending Physician:

ours after death.

eral Director: After this certific filled in by the funeral director, Hospital 24 hours Funeral completed To the within 2

28a-f show aţ

27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified

and Mental Hygiene. is marked other than

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

2310

State Registrar

Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my point, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{3. \text{ Time of Death}}{2:50p}$ Physician/ Note 1 - 29, 2010 Year D. Valdez Lester Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 1904 Erie Street Apt.2 Hyattsville Prince Georges . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🖾 M 2 🗆 F Hours 220-41-1397 7/04/1994 16 **Director** Maryland Usual Residence of Decedent 28a-f shov Ħ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Montgomery Silver Spring 1 Yes 2X No 10e. Street and Number ö 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 504 Domer Avenue Apt.203 20912 USA items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: White Completed 3 Widowed 4 Divorced Cuban Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Student Highschool other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dermit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evenore. ည Damian Valdez Aida C. Cangas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aida Valdez/Mother 504 Domer Avenue #203 Silver Spring, Md20912 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burlal 2 Cremation 3 Removal from State Gate of Heaven 12/3/2010 Silver Spring, Md 4 Donation 5 Other (Specify) Signatur uneral Service Lixen ee PATET ACTOR ACTOR PARTICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Ewin disease or condition monts Medical resulting in death) Due to (or as a sequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atte page 2 should be detached for in the past 12 months? Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛂 No Other: Certificate: To sister's 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) the funeral 27. Manner of Death home 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 4 hours after death uneral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) **U52** Dec 2,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Loeb MD 1650 Orleans Street Baltimore, Maryland 31. Date filed (Month, Day, Year, Registrar's Signat State OEC 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Theresa Jenevieve Woolfolk P M December 2010 9:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12700 Woodbridge Court Prince George Bowie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 2 Year) May 22, 1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🍱 F Months Days Hours Min Director 578-34-8529 Yrs DC 89 Usual Residence of Decedent 10b. County 10a. State death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits or 28a-f si notified 1 X Yes 2 No Maryland Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 12700 Woodbridge Court 20721 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after African 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed Year or Dates American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Educator Government ith and Mental Hygie 27 is marked other r traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Edward Preston Blair Elizabeth Patrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Joyce Adele White - Daughter 8404 Cinema Court Clinton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln

Memorial Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 10 December 4 Donation 5 Other (Specify) Suitland, Maryland 2010 21. Sig ure of Furieral 3 vice one 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE Washington, DC 23a. Part Lever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a consequence of ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has performed? ☐ Yes 2 A No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 XNo ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 AResidence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 \square Pending s after death.

I Director: Af Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and atle of certifier 29d. Date signed (Month, Day, Year) D0068418 December 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Pash, MD 1221 Mercantile Lane Largo, Md. 20774 31. Date filed (Month, Day, Yea 32. Registra 's Signa State DEC 0 9 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wilson Dver P. 1830 December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Care & Rehab. Crofton Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ Months Days Hours Min (Month, Day, Year 04 11] Director 421-22-9564 84 1926 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6808 Nashville Road 20706 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☑ Yes 2 ☐ No 1944-Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Specify: White Completed 1946 Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federa1 Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dyer P. Wilson, Sr. Edna Mae Davidson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy P. Wilson/ Wife 6808 Nashville Road Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 12/09/2010 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home . Signature of Fener Service Licen 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last s been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) Year 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was ar After this certificate has I page 2 performed 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No Certificate: To 4 Prsing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) nd title of d 29c. License number 29d. Date signed (Month, Day, Year) D53111 20/0 06 aun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIDEWATER COLONY MD

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State Registrar 31. Date filed (Month, Day, Year)

32. Registar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item 1 state #23A, Prt1, line A & B, per physician of Death WCHD, E.T Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DONNA LEE WELLER Year Medical 7217 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Medical Cente <u>Peninsula</u> Sbur Wicomico **Funeral** 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Director 330-26-4667 Hours Min. 8-11-1934 76 Yrs. ILLINOIS Usual Residence of Decedent 28a-f shov within 72 hours after death with the Maryland must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits DELAWARE SUSSEX **DAGSBORO** 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 31259 DOGWOOD ESTATES DRIVE 19939 UNITED STATES "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black, White, etc. 3 - Widowed 4 - Divorced 1 ☐ Yes 2 X No Specify: Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other MEDICAL RECEPTIONIST HEALTHCARE Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ? ည ARTHUR V. LOHSE 1 and 2 should b f Health and Mer item 27 is mark FRANCES TAFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN LEE WELLER/SON 171 MERCURY WAY, BERKELEY SPRINGS, WVA. 25411 20a. Method of Disposition permit. Page 1 a
Department of H
Important; If ite
any injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) MELSONS CREMATORY 12-7-2010 FRANKFORD, DELAWARE Since the of Funer I Service Lice 1 ee MELSON FUNERAL SERVICES, LTD 38040 MUDDY NECK RD, OCEAN VIEW, e disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, latitude. List only one cause on each line. shock Sepsis Interval Between Onset and Death Pnysician/ Medical Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Examiner** Multisystem Organ System Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician by Physician/Medical Box 68760 the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No 23d. Date of delivery Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has t irector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 No **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

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State

Registrar

gistrar's Signature

Carroll St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 A M Mary Rebecca Williams November 6:58 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. **84** 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 578-40-2380 1 M 2 X F Days Hours Country)
Poolesville, MD Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director must be notified Prince George's Fort Washington 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 6801 Bock Road Apt 436 20744 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: Black 3 x Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Evangelist Religious Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Eleanor Louise Turner Curtis Lee Brent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deena Collier (Daughter) 8006 Rosaryville Rd Upper Marlboro, MD 20772 Saltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 12/7/2010 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Brentwood, MD 20722 Road 23a. Part 1. Inter the disease, or implications that calls of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ erosclerote Cardiovaccul disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 1 Yes 2 No Yes To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work?
1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060100 11-30-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA BLVD Sast, Silver my 31. Date filed (Month, Day 32. Registar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MontDec. Day 4 2010 2:15 p M Physician/ Charles Η. Weaver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1875 McDuff Ct. Sykesville Carrol] 6. Sex 1 X M 2 □ F Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 579-48-1661 Director Jan. 8, 1933 Washington, DC Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No 28a-f Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 1875 McDuff Ct. 21784 U.S.A12. Was Decedent Ever in U.S. Armed Forces 1 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify. 3 XXWidowed 4 □ Divorced Year or Dates White ed other than "natu event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Guardian Tree Experts College (1-4 or 5+) Mental Hygiene. Tree Expert Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Charles H. Weaver, Sr. Dorothy E. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> item 27 i Charles Weaver (Son) 1875 McDuff Ct. Sykesville, MD 21784 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Chesapeake Crematory: 12/10/2010|Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service License 9013 Annapolis Rd. Lanham, MD 20706 ender 23a. P. 1. Enter the disease, or commeations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, or heart failure. List only ne cause on each line. ediate Cause (Final Physician/ MMONAG Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury that in the cause (Disease or iinjury that in the cause (Disease or iinjury that in the cause (Disease or iinjury that in the cause of the caus Examiner Due to (or as a consequence of): that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 XNo 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗌 No ieral Director: A filled in by the fr ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral I

completed filled Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death December Physician/ 2010 2:15PM I. Washington Jr. William Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Livista Medical Plata hartes If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F (Month, Day, Year) 8-23-1922 Maryland Director 218-14-3504 88 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No LaPlata <u>Maryland</u> Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20646 USA 206 B West Hawthorne Dr 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Bace - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married If Yes, Give 1 Yes 2 KNo Specify. 3 X Widowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Skilled Labor 12 Metro.Transit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thompson Mary <u> William I. Washington Sr.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Washington-Son 15225 Edgebrook Pl.Brandywine MD 20613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Heart Cem 12-13-10 LaPlata, Maryland 20605 Aquasco Rel. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner attending physician and I for use as the burial-transit r Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year signed by the a Part II. Other significant p death /vt not resulting in the un verlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? unmonic 1 Yes 2 No 3 Probably 4 Unknown DR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate has 1 Yes 2 No 2 4 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 1 No 1 🗌 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending death. 2 Accident Investigation 24 hours a er deat e Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 7433 7C Past Office Walderf MD 2060 Abbas Road 31. Date filed (Month, Day, Year, State 32. Registrar's Signature 10 2010 THE CAME Registrar

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Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Washing

the burial-transit nding physician and Box 68760.

Physician/Medical 2 Completed Be

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Medical

use as To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 725

Division or Vital Records, P.O.

IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?
1 Yes 2 No 4☐Pregnant at time of death 9 Unknown 25. Was case referred to medical examiner? Hospital: 2 No 1 Yes

27. Manner of Death Natural 5 Pending investigation 2 Accident 6 □ Could not be 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier

29b. Signature and title of certifier

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy

Other: 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

Year

MD.

Black

2:40

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐Yes 2 No

home

Year

30. Name and address of person who completed cause of death Confles 31. Date filed (Month, Day, Yes 32. Registrar's Signature

3 Ectopic pregnancy

5 Other (specify)

State Registrar

DHMH 17 Rev 1/2001

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dec Day 13 2010 12:15 PM Trent D. Wright Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 108 Patriots Way Cecil E1kton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 D F Months Days Hours Min. 63 Yrs Dec. Director 286-44-4692 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be netified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 XNo MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Patriots Way 21921 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "na any injury or other traumatic even." 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PGA Golf Pro Golf Clubs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Wright Mary Denlinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie A. Wright/ Wife 108 Patriots Way Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/15/2010 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD 21. Signature of Funeral Servicenses 22 Name and Address of Facility
R.T. Foard Funeral Home
259 E. Main St. Elkton, Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.
Immediate Cause (Final Approximate Interval Between Onset and Death Physician Encephalo disease or condition resulting in death) Medical Due to (or as a o insequence of): **Examiner** Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hepatocellul attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Carzinan that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical temochomosos? Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 🗌 No 4 ☐ Pregnant 9 ☐ Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellons II 1 ☐ Yes 2 ₹ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? pertension 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 1 Yes 2 No Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: ျ in 24 hours after death.

the Funeral Director: After this of a projected filled in by the funeral direction. 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending Certificat 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one natui 29d. Date signed (Month, Day, Year) D2639-

Registrar

111 West

32. Registrar's Signature

St. Ste 314

30. Name and address of person who completed cause of death (flem 23a) (Type, Print) N.D

lead

31. Date filed (Month, Day, Year)

2010

Eliton MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3 201 Pear Dec. Maggie J. White 6:39 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12802 Keverton Drive Prince Georges Upper Marlboro 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 5^M2^h5^D3^y1^Y3ⁿ2 5 Countral Months 578-32-0354 85 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Adelphi MD Prince Georges 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ital Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be I Funeral 9200 Edwards Way #1013 20783 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other the many or other the many or other the many or other the many or other the many or other the many or other the many or other Accounting Technician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louisa Lucas James Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William White/Husband 9200 Edwards Way #1013 Adelphi, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Geo. Washington 12/10/2010 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. cc0278 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 years Immediate Cause (Final Parkinsons Physician/ iscose disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Exami Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 Yes Yes 2 XNo Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 🗆 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? ours after death. 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) thin 24 hours at the Funeral C Medical 29a Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the I complex 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year. 10 D47654

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

NW Washington, DC

110 Irving St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlotte Dean,MD

December 6, 2010

20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Edwards Wa	aters Sta 1- For State Registrar	te of Maryland	/ Departmo			d Mental H	-	eg. No. 201	0 :0751	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,	Last) Edward					2. Date of Dea		3. Time of Death 1300 hrs	
	4a. Facility Name (if not institution, 1400 blk. Nalley Terrace)		City, Town, or I andover	Location of Dear	th	4c. County of D Prince Geo		
Funeral Director	577-13-7483	7. Ag	ge (In yrs. last birt 24	_	Under 1 Year Months Days		n	14, 1986	b. Birthplace (State or Foreign Country) D . C .	
faryland 28a-f show any at once.	Usual Residence of Decedent 10a. State 10b. County D. C. none		10c. City, Town Washing						10d. Inside City Limits 1 X Yes 2 No	
death with the Maryland or items 23a or 28a-f shomust be notified at once.										
후 : 베 근		ried Armed Forces? 1 Yes 2 ced If Yes, Give Year or Dates:	? X No	If Yes,	specify Cuban, s 2 🗓 No	Mexican, Puert specify:	o Rican, etc.)	White, e Specify:	Black	
5-0036 led within 72 hours at tygiene. other than "natural the Medical Examin Completed by	15. Decedent's Education (Specif Elementary/Secondary (0-12) 12th	College (1-4 or		during most		on (Give kind of DO NOT use re		16b. Kind of Busine		
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic event, the Medica To Be Comple	17. Father's Name (First, Middle, Land Donald Barksdal 19a. Informant's Name/Relationship	Le	198	o. Mailing Ad		Juanit	a Washir	Maiden Surname) 1gton nber, City or Town, S	State, Zip Code 772	
ore, MD 2 res 1 and 2 shou of Health and N If item 27 is n ther traumatic	Juanita L. Barks 20a. Method of Disposition 1 Burial 2 Cremation		her) 1	4506 N	Marlbor	ough Ci	rcle Up	oper Marlt 20c. Location - Cit Beltsv	oro, Md. ty or Town, State	
Baltimore, MI pemit. Pages I and 28 Department of Health a Important: If item 27 injury or other traum	4 Donation 5 Other Spec		il8	22. Name W . H	and Address	of Facility Tunera	11 Home.	Inc.	n, DC 20010	
Physician Madical xaminer	23a. Part I. Enter the disease/ or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	n each line. a. <mark>Multiple Gunsh</mark> o	ot Wounds						Approximate Interval Between Onset and Death	
iner	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause									
e executed cician and inial - transit dical Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse		1						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	AMENDED 1 23c. If yes, outcor Live birth Pregnant at		Fetal d		Ectopic pregr		23d. Date of del Month	livery Day Year	
P.O. BOX	Part II. Other significant condition	9Onknown				ven in Part I.			e to the cause of death?	
- 8 go o				-			24a. Was autop perfoi	prior deat	re autopsy findings available r to completion of cause of th?	
Division of Vital Records, rate or Attending Physician: The law requirens after death. **I Director: After this certificate has been similar in by the funeral director, page 2 should be ertification: To Be Completed	25. Was case referred to medical examiner? 1 ✓ Yes 2 No			utpatient 3	DOA		ing Home 5	Residence 6 ✓ 0	Yes 2 No Other: Scene	
Division of \\ Ital or Attending Ph. \\ urs after death. \\ ral Director: After the Idled in by the funeral \\ ertification: Teles and the funeral Idled in the funeral \\ ertification: Teles and the funeral \\ ert	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be 28a. Date of Injury FOUND: 1229 hrs 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No Subject shot 28d. Describe how injury occurred Subject shot 28d. Descri								or Rural Route Number, City	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Suicide of Could not be determined (Specify) truck or Town, State) 14 Homicide (Specify) truck 29a Certifier									
To the Ht within 24 To the Ft Completel	29b. Signature and title of certifier	and manner stated.	4~		29c. License O.C.M	number			(Month, Day, Year)	
	30. Name and address of person with Patricia Aronica-Pollak I	MD. Assistant N	/ledical Exam	iner 11	1 Penn Str	eet, Baltimo	re, MD 2120	1		
State Registrar	DED 0.17 14	010 Registra	r's Signature	post						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:49p Kenneth D. Wolfe December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Richcroft Inc. New Windsor Carroll 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year Dec. 19 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Hours Min. Country Yrs **Director** 73 219-76-4413 Maryland Usual Residence of Decedent r 28a-f shov notified at 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Carrol1 New Windsor ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1564 Stone Chapel Road 21776 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 to f Health and Mental Hygiene.
If item 27 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) 5 None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Robert Wolfe Pauline Mae Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Pauline Leach/ Sister 208 East 7th Street, Frederick, Baltimore, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/9/2010 Frederick, Maryland Signature of Funeral Service Lic Stauffer Funeral Homes 1621 Opossumtown Pike, P. A. Frederick, Maryland 21702 23a. Part 1 I ther the disease, or complications that caused the death. Do not enter the mod shock or heart failure. List only one cause transch line. dying, such as ordiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or impury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a detached f 9 Unknown Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 No 1 🗌 Yes 1 Yes eral Director; After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Assisted Living 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 6 K Other (Specify) 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \text{Yes} \quad 2 \sum \text{No} \) Natura! 5 Pending iniury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Kings Drive.

32. Regist ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Brewster,

Kevin J.

31. Date filed (Month, Day, Year)

H0055845

Taneytown, Maryland 21787

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 6, 2010 2157 hrs **Medical Examiner** David F. Winklepleck, Jr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick Memorial Hospital Frederick Date of Birth (MM/DD/YYYYY)
 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 218-21-1748 1 X M 2 F Jan.23,1979 Washington,DC 31 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Frederick Monrovia 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 12092 Stansbury Drive 21770 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Armed Forces? Yes 2 If Yes, Give Year or Dates: 4 Divorced 1 Yes 2 X No specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 2 Electrician Electrical 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lois Mobley Winklepleck <u>David F. Winklepleck</u>, 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N N Lois Winklepleck/Mother 12092 Stansbury Drive, Monrovia, MD 21770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Parklawn
Memorial Park 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify Dec.11,2010 Rockville, Maryland 22 Name and Address of Facility liams, P.A., Funeral Home 21. Signature of Funeral Service Licens 26401 Ridge Road, Damascus, MD 20872 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure, List only one cause on each lin /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ě 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has death? Yes 2 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other:4 Nursing Home 5 Residence 6 Other: 2 V ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification Driver in vehicle/vehicle collision 1 Natural Dec 6, 2010 2130 hrs 1 Yes 2 ✔ No Director: Pending hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Route 80 and Kemptown Church Road, Monrovia, MD within 24 hours a determined (Specify) Major Road / Highway CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa one) (Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number December 7, 2010 O.C.M.E. and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

	1 - State Registrar			Certificate	of Death	and Mer	Re	eg. No.2	0 4	0754
ician dical	Decedent's Name (First, Middle BARBARA L	, Last) EE WILLING					Date of Deat Month 12	Day	Year	me of Death
niner	4a. Facility Name (If not institution	give street and number)		4b. City, T	own, or Location o	f Death	-	4c. County		
V.	23496 Deal Isl		// / /		ance Year If Under 2	04 Hrs. 0	D-1(D' 1)	Som	erset	
al or	5. Social Security Number 212-40-9671	6. Sex 7. Ag	ge (In yrs. last birt.		Days Hours	Min.	Date of Birth (Month, Day, 08–16–		9. Birthplace (5 Country) M	tate or Foreigi
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Ins	ide City Limits
ō		set		Chance						Yes 2 □ No
once. To Be Completed by Funeral Director	10e. Street and Number 23496 Deal Is1	and Road		10f. Zip 0	ode 2182	1	1		What Country?	
Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decede	nt of Hispanic Orig y Cuban, Mexican		/ Yes or No-		ce - American Indi	an,
by Fur		ed Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		If Yes, specif	-	ĭ, Puèrto Ric	an, etc.)	Specify	ck, White, etc. y: Whit	e
		's Education	16a.	Decedent's Usual	Occupation	t of working	- 1	l 16b. Kind of B	usiness/Industry	
Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+) TO	(Give kind of work life. DO NOT use lephone			nkor	Comm	unicatio	ne
ပ္ပ	17. Father's Name (First, Middle,	L cot)	16	Tehnone				Maiden Surnar		113
To Be	Osborne Ford	,				uise S		viaiden Surnar	ne)	
-	19a. Informant's Name/Relationsh	nip (Type. Print)	19b.	Mailing Address (Street and Numbe	er or Rural R	oute Number	; City or Town,	, State, Zip Code)	
	Jack Willing S	r.		496 Deal		Rd., C	Chance,	MD. 2	1821	
	20a. Method of Disposition 11 ☑ Burial 2 ☐ Cremation	3 ☐Removal from State	20b. Place of cemeter	Disposition (Name y, crematory or oth	of erplace)	Date	•	20c. Location	- City or Town, St	ate
	4 □ Donation 5 □ Other (Sp	pecify)		reek Cem			<u>-201¢</u>		nce, MD.	
	21. Signature of Funeral Service	Licensee	M00295	1	Address of Facilit			ıneral	Home e, MD. 2	1952
n al er	My ck, or heart failure. List Im diate Cause (Final dia ase or condition resulting in death) Sequentially list conditions,	a. Due to (or as	ine.		onary 4	ibro	555		Interv Onse	al Between t and Death
edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of							
Physician/Medio		d							l l	
	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		e pf pregnancy 2 □ Fetal death at time of death	3 ☐Ectopic pre 5 ☐ Other (spe					ate of delivery onth Day	Year
þ	Taren. Other significant conduct	1 ☐Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal death at time of death	5 ☐ Other (spe	cify)			bacco use con		
þ	Taren. Other significant conduct	1 ☐Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal death at time of death	5 ☐ Other (spe	cify)		1 □ Yo	bacco use con es 2 No	onth Day tribute to the cau 3 Probably Were autopsy fin prior to completic death?	se of death? 4 Unknow dings available on of cause of
Completed by	Tatili Other significant condine	1 ☐Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal death at time of death	5 ☐ Other (spe	se given in Part I		1 □ Yo	bacco use con es 2 No n 24b. sy med? 2 No	onth Day tribute to the cau 3 1 Probably Were autopsy fin	se of death? 4 Unknow dings available of cause of
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To Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital: 1 Inpat 28a. Date of Inj (Month, Digation)	2 Fetal death at time of death but not resulting in lient 2 ER/Ou lury 28b.1	5 ☐ Other (spe	use given in Part I	e of Death (Cursing Home	1 □ You 24a. Was a autops perform 1□ Yes Check only on 5 1 Reside	Me bacco use con es 2 □ No con 24b.	onth Day Itribute to the cau 3 Probably Were autopsy fin prior to complete death? 1 Yes 2 N	se of death? 4 Unknow dings available on of cause of
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Certification: To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpat 28a. Date of Injuicton building, e g Physician: To the bes Examiner: On the basis and manner s	2 Fetal death at time of death but not resulting in the properties of the properties of examination and the control of the properties of examination and the control of the properties of examination and the control of the properties of examination and the control of the properties of examination and the control of the properties of examination and the properties of the p	tpatient 3 DOA fime of njury M rm, street, factory, e, death occurred a d/or investigation,	26. Place Other: 4 Nu c. Injury at Work? 1 Yes 2 Office	e of Death (Cursing Home 28c No 28f and place, and ath occurred	1 Your Yes 24a. Was a autops perform 1 Yes 24b. Check only on 5 Meside in Describe his continuous for the continuous formatten in the second of the continuous formatten in the second i	Min bacco use con es 2 □ No 24b. Symeot? 2 □ No 24b. Symeot? 2 □ No 24b. Symeot? Ence 6 □ Ottow injury occu treet and Num n, State) Eause(s) and material and place	onth Day Intribute to the cau 3 Probably Were autopsy fin prior to completic death? 1 Pres 2 N Ther (Specify) Interest or Rural Roun The canner as stated, and due to the completic to the canner as stated.	se of death? 4 Unknow dings availabl on of cause of lo e Number, ause(s)

Registrar

State

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31. Date filed (Month, Day, Year)

Hospital or Attending Physician: 24 hours after death. After Division I Director: To the

24b. Were autopsy findings available prior to completion of cause of Other Nursing Home 5 Residence 6 Other Scene 1 X Natural 1 Yes 2 No Pending 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

> 29c. License number O.C.M.E.

CMOS 30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

State Registrar

31. Date filed (Month, Day, Year) 2

parks

29d. Date signed (Month, Day, Year)

July 29, 2010

een Onset and

Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10b Per FH G912 2/18/2011 IH
State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dec. Physician/ 2010 Donald Μ. Z immerman 9:04 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3142 Gracefield Rd. #509 Silver Spring Montgamery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min March 11, 1916 **Director** 517-07-2658 94 Montana Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Prince George's 1X Yes 2 No Maryland Silver Spring Montgamery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3142 Gracefield Rd. #509 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Civil Servant Veterans Administration other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ၉ Mike Zimmerman Sara Verhaulst permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5325 Lynn Lane Ellicott City, MD 21043 Diane Armstrong (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. Nat. Memorial Pk | 12/7/2010 | Laurel, Maryland 21. Signature Funeral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 art 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart lailure. List Immediate Cause (Final Physician/ Acute Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to for each consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director; After this certificate has performed? Yes 2 XN 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home St Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Detrifying Nysteam to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo36716 nden December 6,2010 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Kundrat, MD 3110 Gracefield Rd. Silver Spring, MD 20904 31. Date filed (Month, Day, Year)

State

Registrar

7 2010

DEC 0

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 10, Physician/ 8:01 AM KENNETH 2510 ALLEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** aurel Regional Hospita Prince George's Laurel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, AUG • 9 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Months 1 🗆 M 2 🗆 F WASHINGTON.DC ^{Year)} 1940 212-82-9651 70 Yrs. Director Usual Residence of Decedent show 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director or 28a-f sh notified a Yes 2 No PRINCE GEORGE'S MD COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ral", or items 23a o Examiner must be Funeral 10205 BALTIMORE AVENUE #8110 USA 20740 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo WHITE Specify: 3 Widowed 4 Divorced "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JAMES ALLEN AIMEE ROUBAUD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN MARCELLE/NURSE 817 VARNUM STREET N.E. WASHINGTON, DC 20017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place, 12/28/2010 RIVERDALE CREMATORY RIVERDALE, MARYLAND once, Signature of Funcial Socioe Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Chronic Physician/ Obstructive disease or condition Medical resulting in death) Due to (or as a consequence of) **Ê**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events southing in death) Lect. Examine Due to (or as a consequence of). burial-transit executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 9 🔲 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursin Home 5 Residence 6 Other Sective 2 🔽 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA မ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one d title of certifie 29b. Signature an 29c. License number December 10, 2010 D0070842 7300 Van Dusen Road

Registrar DHMH 17 Rev 7/2009

State

Regional

Hospital,

Emergency

MD 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laurel

Allen, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec. Joanne V. 28 2010 Atwood Medical 10:10 A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Keswick Multicare Center Baltimore N/A5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🏋 Months $Julv^{\textit{(Month, Day)}}$ 1<u>944</u> 215-42-0060 Director 66 Maryland Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 🗓 Yes 2 🗆 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3849 Rolland Ave., 2nd Floor 21211 United States items ; 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No 14 Bace - American Indian Black, White, etc. ò hours after þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. "natural", 1 ☐ Yes 2x No Specify: Specify: White 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 11 Postal Worker US Mail System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J. Figgs Delma Stansbury and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Atwood Daughter 1313 Weldon Ave., Baltimore, Maryland 21211 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonge. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 12/27/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee ${
m Alyson}\;\;{
m Taylor}$ 22. Name and Address of Facility Cremation Society of Maryland Vile Co 299 Frederick Rd. Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) a. RENAL CUI CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Unknown 5 Other (specify) Day Year ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed Dichetes Mellitus Type 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 245/10/denia 24a. Was an performed? Yes 2 No eral Director: After this certificate Ifiled in by the funeral director, pag orancy Actor 2 🗌 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 296. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 Jose Avila. Jr. 26 4:40 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number Funeral 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, 1 **X** M 2 □ F Months Days Hours Min. Day, Year Director 550-42-8880 79 <u>California</u> Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 ☐ Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 905 Sibley Road 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ Black, White, etc. ^{2 □}No ⁄e Korea 1 Never Married 2 X Married 1 X Yes If Yes, Give Maryland 21215-0036 1 X Yes 2 □ No Specify: Specify: White and Mental Hygiene. is marked other than "natural", 3 Divorced Completed Mexican Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Photographer Photography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Jose Avila Nestora Chavez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trans Dorothea M. Avila, wife 905 Sibley Road Towson, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/27/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee George 22. Name and Address of Facility Cremation Society of MD, Inc. MacNabb 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTATE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 2 🔲 No the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform After this certificate Yes 2X No 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X** No 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nuran Practioners To the best of my knowledge, death occurred at the face, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) ZÓ

31/

DECEMBER

DHMH 17 Rev 7/2009

State

Registrar

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP

31. Date filed (Month, Day, Year)

UEC 2 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici Medi		1. Decedent's Name (First, Middle, Thurman E. Bowe	,				2. Date of Dea	ath	2, 2010	3. Time o	of Death
	Exami		4a. Facility Name (if not institution, 1203 Taylor Ave	give street and number)		4b. City, Town, Baltimo	or Location of Death		4c.	County of Death	•	
	Funeral Director		219-28-2610	6. Sex 1	e (In yrs. last birthd 78 Yr	Months Day		8. Date of Birt (Month, Day Dec 1		9. Birth Cour Mary	place (State of Try) Land	or Foreign
	Maryland 28a-f show	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltime	ore	10c. City, Town o	e					10d. Inside C	ity Limits
	h with the ns 23a or nust be n	neral D	10e. Street and Number 1203 Taylor Ave	•		10f. Zip Code 21227			_	zen of What Cou ted Stat		
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 X Marri 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 AYes 2 If Yes, Give Year or Dates.		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N	Hispanic Origin? (Speban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	i	14. Race - Ameri Black, White, Specify: Whi	etc.	
Maryland 21215-0036	within 72 hor giene. er than "nat the Medica;	Completed	15. Deceden (Specify only highes Elementary/Seconday (0-12)		i+) (G	ecedent's Usual Occ Give kind of work don de. DO NOT use retire ervisor	e during most of work	ing	Balt	nd of Business Ir timore G ctric		
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	d 2 shoul alth and h	1000	19a. Informant's Name/Relationsh			-	et and Number or Rura		-			
Baltimore,	Page 1 an ment of He tant: If item jury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (See	3 ☐ Removal from State	20b. Place of D	isposition (Name of demoter 2 others y (Crowns	sville 12/	Date 29/2010	20c. Loc	cation - City or T vnsville	own, State , Mary	land
Balt	permit Depart Import any inj		21. Semature of Eneral Service Licensee 22. Name and Address of Facility AMBROSE FONERAL HO 1328 Sulphur Spring RD., Arbutus									
	Ph₊sician/ ⊭ Medical	8 9	23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aly one cause on each line	TIVE H	GART FA		or respiratory am	est,		Approxima Interval Be Onset and	tween Death
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09/	ate be ex ohysician the burial		resulting in death) East			ARTER	IAL DIS	EASE			YEA	hrs
). Box 68760	requires that the death certificate be ex been signed by the attending physician should be detached for use as the buria	mpleted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)	ncy		2	23d. Date of deliv	,	Year
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Division of Vital Ro To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag ပြ Be မ Certificate:

delivery Day Year to the cause of death? Probably 4 hknown autopsy findings available to completion of cause of SACRAL DECUBITUS 1 Yes 2 No ULCERS 1 ☐ Yes 2 🗖 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

29a. Certifier only one)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier , hy 29c. License number D ZZ83Z

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STREET, ELKRIDGE, SOON 5808 MAIN KIM

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death s Name (First, Middle, Last) 2. Date of Death 3. Time of Death BISCOE Physician/ 5:30 PM 0 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 4211 Fredrick Ave. Baltimore N/ASocial Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 08/3/1921 1 □ M 2 📭 Days Director 218-12-3006 89 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1X Yes 2 ☐ No MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a 4211 Fredrick Ave. 21229 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Domestic Engineer Private Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Fitzgerald Biscoe Ethefl Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Chase(niece) 4211 Fredrick Ave., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State any injury or conce. 1 Durial 2 Dremation 3 Removal from State Josephiemerordhir Pf H And Crematory 4 Donation 5 Other (Specify) Baltimore,MD 12/22/10 21. Signature of Funeral Service Licensee PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Remonary Disease Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physlcian; The law requires that the death certificate be executed signed by the attending physician and deetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown 5 Other (specify) Month Day Pregnant at time of death Year Yes 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident hin 24 hours after death.

the Funeral Director; A

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DHMH 17 Rev 7/2009

Portrent known as Glennie Mae Browin Baltimore. Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	ase Type or Pri						gible.	
		For State	State of IVI	-	epartment of I Certificate of I		ivientai Hy	giene	10 :076	3
		Registrar 1. Decedent's Name (First, Middl	le Last)		Certificate of	Deam	2. Date of De	Reg. No.	10.7	
Physicia		Glennie	M .		Brown		0 Month		Year 2010 11-46	
Medic Examin		4a. Facility Name (if not institution	n, give street and number)			or Location of Death		1	nty of Death	
<u> </u>			pital of Bo	outimore	Baitin	ione City	4			
Funeral Director		5. Social Security Number 212-34-5021	6. Sex 7. Ag 1 ☐ M 2 ☐ X F	e (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 03 19	th y, Year)	Birthplace (State or Fore Country)	eign
N		Usual Residence of Decedent		77 Y	10.		03 19	33	L NC	
/and f shov	tor	10a. State 10b. County		10c. City, Town					10d. Inside City Lim	nits
Mary 28a-1 notifie	Funeral Director	MD NA		Balt	imore				1 🔀 Yes 2 □] No
th the 3a or t be r	ral	10e. Street and Number	h		10f. Zip Code				f What Country?	
ath w	nue	3804 Barring	12. Was Decedent I	Ever in IIS	13. Was Decedent of H	21215	secify Ves or No-		S . A .	
or its	by F	1 Never Married 2 Mar	Armed Forces?		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		lack, White, etc.	
2 hours after death with the Maryland 2 hours after death with the Maryland "natural", or items 23a or 28a-f show		3 X Widowed 4 ☐ Divorced	d If Yes, Give Year or Dates.		1 ☐ Yes 2 ☐XNo	Specify:		Specif	fy: Black	
filed within 72 hours after death with the Maryland all Hygiene. 1 other than "natural", or items 23a or 28a-f sho vent, the Merical Examiner must be notified at	Completed	15. Decede (Specify only high	ent's Education est grade completed)	I (Decedent's Usual Occup Give kind of work done	during most of worl	king	16b. Kind of	Business Industry	
vithin iene.	Con	Elementary/Seconday (0-12) 12th grade	College (1-4 or 5	D+)	ife. DO NOT use retired, Unemplovn			State	of Maryland	3
filed valued valued valued valued vent,	Be	17. Father's Name (First, Middle,		1	OHEMPIOYI	18. Mother's Nan				_
ld be la Menta	욘	Ellis H. Low	ery			Leah F	ormey			
d 2 should be filed within 72 hours. at his and Mental Hygiene. The Tris marked other than "natura is traumatic event, the Merical Estraumatic event.		19a. Informant's Name/Relations		I .	Mailing Address (Street					
S & P & E &		Conust Linen- 20a. Method of Disposition	-Son		28 Roxy Disposition (Name of	rive, B				
permit. Page 1 a Department of H Important: If ite any injury or ot		1 Burial 2 ☐ Cremation	3 Removal from State		crematory or other pla	· ' i	Date		n - City or Town, State	
mit. Poartme		4 Donation 5 Other (3		l No	rthwest 22. Name and Addre		2011	Lelan	nd. NC	
and med	2. 0	Mymi	B. Ket	٩	22. Name and Addre March F/ 14300 Wab	H West ash Ave	Balt	imore.	Md 21215	1
		23a. Par 1. Enter the disease, or shock, or heart dilure. List of	complications that caused	d the death. Do no					Approximate Interval Between	
Physician/	2 1	Immediate Cause (Final disease or condition	Hypox		inatory to	gime			Onset and Death	
Medical Examiner		resulting in death)	Due to (or as	a consequence of)	:					
	jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	:				_	
uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events								
is a e	EX	resulting in death) Last	Due to (or as	a consequence of)	•					
ate be physicii the bu	dical		d							
ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						
atten for us	Physician/Medi	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No		2 Fetal death	3 Ectopic pregnants Other (specify)	су		1	Date of delivery Month Day Year	
the de by the ached	hysi	9 Unknown	9 🗌 Unknown							
s that gned to	by P	Part II. Other significant condition	9	out not resulting in	the underlying cause gi	ven in Part I.			ntribute to the cause of death?	
quire en siç ould b	ted	Atrial Fibrillo					1 🗆 '	Yes 2 ☑ No	3 Probably 4 Unkno	own
law re as be	Completed	Hypertension	1				24a. Was autop	osy	. Were autopsy findings availab prior to completion of cause of	ble of
: The cate I							1 Yes	rmed? 2 No	death? 1 Yes 2 No	
sician certifi rector	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		Oth	lace of Death (Chec				_
g Physer this eral d	e: 10	27. Manner of Death	28a. Date of inju	ent 2 ER/Outp	ne of 28c. Injur	y at	ome 5 Resid			
ath. rr. Afte	Certificate:	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident Investi	gation	y, Year) inju		k? Yes 2 □ No				
r Atte ter de irecto	ertif	3 Suicide 6 Could 4 Homicide determ		ury - At home, farm	n, street, factory, office		28f. Location (S City or Tow		ber or Rural Route Number,	
oital o urs af eral Di							i)			_
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Medical E	Physician: To the best of Examiner: On the basis of earth of the participant of the parti	xamination and/or i	nvestigation, in my opini	on, death occurred a	at the time, date a	nd place, and du	lue to the cause(s) and manner s	stated.
Го the vithin Го the сощрі	Σ	29b. Signature and title of certifier		best of my knowled	29c. Licens				ed (Month, Day, Year)	
) (gl gu d	_		Ri	58 000		Decem	per 19,2010	
5V		30. Name and address of person		eath (Item 23a) (Ty	pe, Print)					
,		Kotrina A. 31. Date filed (Month, Day, Year)	Abadilla, MD) Si	ngi tospita	11 of Ba	itimore			
Stat Registra		DEC 2 8 20	10 32; Registra	ar's Signature	Med					
HMH 17 Rev 7/20		NEW MA MA	- Barrens	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:10 AM d 2 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Village baltimore harles Himore care If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 M 2 K F (Month, Day, Year) Director 250-78-5476 65 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2841 Boarman Ave 21215 U.S.A. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rnit. Page 1 and 2 should be filed within 72 hours after dea cathent of Health and Mertalle Hygiene. octant: If item 27 is marked other than "natural", or item or in the raumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 XNo Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 Widowed 4 Noivorced Specify Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th grade College (1-4 or 5+) Private Duty Nursing Homes To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of James English Rosalie White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly English Daughter Boarman Ave, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cther (Specify) Zion 12/23/2010 Baltimore, Md 21. Signature of Funeral Service Licens 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ pronary disease or condition resulting in death) Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔯 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 286. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At hom-, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatire and title of certifier DHYSI CIAN 7543 12-17-10 Name and address of person who completed Lause of death (Item 23a) (Type, Print) PREETINDER 1940 W. BALTIMURE ST. BALTIMUR E, MP 21 223 SANDHU M.A

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Medical LOUISE DECEMBER 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🕱 F Hours 0872471923 Director 181-18-5851 87 MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Frederick Frederick 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6351 Spring Ridge Parkway 21701 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 KWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 0wn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry E. Temple Victoria Hipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6200 Glen Valley Terrace Unit E Frederick, MD 2170 Terry Jacobson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2010 Woodbine, MD Journey Crematory 22. Name and Address of Facility Maryland Cremation Services 21. Signature of Funeral Service Lig wita Baltimore, MD 21203 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death xacerbation Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day Year signed by the a 1 Yes 2 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed Yes 2 No 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 🗌 Yes 2 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Automore, within 24 hours after death.

To the Funeral Director, After a funeral director, After a funeral filled in by the fur 1 Natural 5 Pending work? Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier illoug MDD 65443

DHMH 17 Rev 7/2009

State

Registrar

Frederick

400

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EDWIN WAYNE BOWMAN DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1.X M 2 - F Days 03/12/1952 Director 215-48-9499 58 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Mt. Airy Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12993 Maple Ct. 21771 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ? Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Construction worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Crawford Bowman Violet Louise Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12993 Maple Ct. Carolyn Lee Bowman / Wife Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2010 Final Journey Crematory Woodbine, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services eanta 190mas P.O. Box 1413 Baltimore, MD 21203 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte 4 ☐ Pregnant at time of death g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical-26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniurv work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

Registrar

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Albert C

400 W

7th St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Villarosa

052056

Frederick, ms 21701

12/27/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day DECEMBER 26 Physician/ Year BARBARA BIELANSKI 23 25 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHN'S HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 29, 1938 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2x F Hours Min. 249-56-3179 72 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified a MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o Funeral 328 Worton Road 21221 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
sant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mn 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tax Preparer H&R Block 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Floyd Gardner Jane Langley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Kellner 7506 Battle Grove Circle Balto, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any Injury or of once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Holly Hill Cemetery 12/30/10 Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licenses Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Ischemic Stroke disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events Daw to (от яв в воляновного of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has death? Yes 2 No 1 ☐ Yes 2 ☐ No Be (Division of Vital 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🔀 No ဂ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Director; Aft Accident Investigation the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

PAYAM

31. Date filed (Month

RES - 000

EASTERN AVENUE

DECEMBER, 26, 2010

21224

BALTIMORE, MD.

M.D

4940

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHASSEL

Year)

28

Day,

10-09805 Kenneth Bailey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cenneth Bailey		1- For State	tate of Maryla		artment of <i>rtificate</i> o <i>f</i>			Menta	al Hy		20	1	0758
Physician		Registrar 1. Decedent's Name (First, Midd	lle,Last)						7	2. Date of Deat			3. Time of Death
ical Examine	er	Kenneth Ro	ger B	ailey						Month December			0035 hrs
		4a. Facility Name (if not instituted University Hospital	on, give street and nu	mber)	14	lb. City, To Baltim		ocation of	Death		4c. County of	Death	
E		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under		If Under :	24Hrs	8 Date of Bir	th(MM/DD/YYYY)	9. Birtl	pplace (State or
Funeral Director		215-80-6919			. 0	Months		Hours	Min.	12/22/		Foreign	
	ŀ	Usual Residence of Decedent	1 M 2 F	-	OU Yrs.		L			12/22/	1555		110
any	t	10a. State 10b. County		10c. City	, Town or Locati	on							10d. Inside City Limits
nnd Show	ᆡ	MD		Ba	ltimore								1 Yes 2 No
Marylz 28a-f	֓֓֓֓֓֓֓֓֓֓֓֓֓֟֓֓֓֓֓֡֓֡֓֓֡֓֡֓֡֓֡֓֡֡֡֡֓֡֓֡֓֡֡֡֓֡֓֡֓֡֡֡֡֓֡֓	10e. Street and Number				10f. Zip (1	0g. Citizen of Wha		try?
15-0036 filed within 72 hours after death with the Maryland Hygiene. do other than "natural", or items 23a or 28a-f sho the must be notified at once.	Funeral Director	7301 Belair F					206				U.S.		
th wit tems 2	<u>e</u> ra	11. Marital Status 1 Never Married 2 M	arried Armed Fo	edent Ever in U prces?						cify Yes or No Rican, etc.)	- 14. Race - White,		an Indian, Black,
er dea			1 Yes	2 No	1	Yes 2	No.	specify:			Specify:	Whi:	te
urs aft	9	15. Decedent's Education (Spe	or Dates:		16a. Deceden	rs Usual C	ccupatio	n (Give kir			16b. Kind of Bus		
72 hor		Elementary/Secondary (0-12)	College (1	-4 or 5+)			ing life. [OO NOT us	se retire	ed)			
5-0036 steed within 72 hours a sygiene. other than "matural the Medical Examin	Completed	12			Hand	yman					Const	ruc	tion
ID 21215-00; should be filed with and Mental Hygiene and Mental Hygiene in marked other it matte event, the Mes		17. Father's Name (First, Middle Wilford Paul	•				18		,	First, Middle, M [a Farl	Maiden Surname) ⊖V		
2121 ald be fi Mental marked:: event,	10 26	19a Informant's Name/Relations	•		19b. Mailing	Address	(Street				nber, City or Town	, State,	Zip Code)
E 0 - 0 - 1	_	Ezekiel Baile			2922	Hunt	ingo	on A	ve	Baltim	ore, MD	212	11
		20a. Method of Disposition	a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremation of One of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To								Fown, State		
Baltimore, lorumit. Pages I and longuranti of Heal longuranti. If item injury or other tra			Burial 2 Acremation 3 Removal from State Final Journey Crematory 12/24/2010 Woodbine,								ne,	MD	
Baltimo permit. Page Department important: Important:	1	21. Signature of Funeral Se ce Licens ono a Arshall 22. Name and Address of Facility Maryland Cremation Set											
	1	23a. Part I. Enter the disease, or	me	mu	Shall						timore,		21203 Approximate Interval
Physician /Medical		failure. List only one cause	on each line.								est, shock, of flea		Between Onset and Death
Examiner	-	Immediate Cause (Final disease or condition resulting in death)		consequence of		ovas	cula	r Dis	eas	e			
		Sequentially list conditions,	b										
	힐	if any, leading to immediate cause. Enter Underlying Cause		consequence of	of):								
_	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	of):								7
and and	#		d						_				
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Box 68760, e death certificate be the attending physic ed for use as the burner.		IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, c	outcome of preg	Inancy	al death	3	Ectopic p			23d. Date of o		ay Year
x 6 th cert the cert ruse a	Physician/M	past 12 months?		ant at time of de	acth =	ner (Speci	fy)				-		
Bo he dea	څ		known 9 Unkno		andina ia tha	adaduina.	nougo eix	on in Port		23a Did to	phacco use contrib	ute to t	he cause of death?
Division of Vital Records, P.O. in or Attending Physiciae: The law requires that the rs after death. The Director: After this certificate has been signed by the finneral director, page 2 should be detach that the finneral director, page 2 should be detach that the finneral directory and page 1.		Part II. Other significant condi	•					en in Pari	1.	1 Yes			ably 4 V Unknown
ords, I	Completed	Chronic Obst	ructive Pu	ulmonary	, Diseas	e (CO	20)		_	24a. Was			opsy findings available
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tal Recipion The certificate ector, page		05 Man and assessed to madin	 			2	Place o	of Death (C	hock o	1 Yes	2No1	✓ Ye	s 2 No
Vital Rec ysiciso: The his certificate director, page	۱۵	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Line and the line	npatient 2 🗸	ER/Outpatient		10	41			Residence 6	Other	
of Ving Physical After this uneral direction	<u> </u>	27. Manner of Death	28a. Date	of Injury Day,Year)	28b. Time of Ir	njury 2t	Bc. Injury	at Work?	1	28d. Describe I	how injury occurre	d	
ion of tending Pheath. or: After the funeral			ding estigation	, Day, rear,			1 Ye	s 2 N	10				
or At or At or At or At or At in by	Certification:	3 Suicide 6 Cou	id not be 28e. Place	e of Injury - At h	ome, farm, stree	t, factory,	office bu	ilding, etc.	2	28f. Location (S		r or Rur	al Route Number, City
Divis Hospital or A Runeral Dire tely filled in E	5	4 Homicide	ermined (Specify)										
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physiciae: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician produced in by the funeral director, page 2 should be detached for use as the beautification.	흥		'hysician: To the bes aminer: On the basis o	it of my knowled of examination a	lge, death occur and/or investigat	red at the li ion, in my	ime, date opinion, e	e and place death occu	e, and c urred at	lue to the caus the time, date	se(s) and manner and place, and du	as state ie to the	ed. e cause(s)
To the within 2 To the complet	Medical	29b, Signature and title of certific	and manner st	tated.			License				29d. Date signe		
DT.		(calorbas					O.C.M	l.E.			December 2	20, 20	10
(V)	1	30. Name and address of persor	who completed caus	se of death (Item							1	00	
			Assistant Medica		111 Penn	Street,	Baltim	ore, MD	2120	1			
Stat	te	31. Date filed (Month, Day Year	010 33 Re	egistrar's Signat	o par	Les							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:05 pm Sheila Ann Bowser Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** timore Shuare Hos ranhlin Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 212-60-5038 **Funeral** 1 □ M 2 🔀 F Months Hours Min. (Month, Day, Year Ct. 13, 1 59 MD Director Oct. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Rosedale MD 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21237 7401 Gumspring Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No 1 Never Married 2 K Married <u></u> Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry mentary/Seconday (0-12) 12th College (1-4 or 5+) Sally's Hairport Barber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Genivita Arbutus unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7401 Gumspring Road Baltimore MD 21237 Perry Bowser /husband Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bayview Crematory 1 Burial 2 Cremation 3 Removal from State 12/27/10 Baltimore MD 4 Other (Specify) 22. Name and Address of Facility 300 Mace Ave, Balto. Connelly Funeral Home of Essex 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 20519 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner with liver cirrhosis Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine patorenal sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the fune al director, Be examiner? 1 ☐ Yes 2 ☑ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Matural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

arks

ladia Abdul Malik, mo 9000 Franklin Square Drive Baltimore, mo 2123

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N. malel

2. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

December 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec ^D2010 Physician/ Jean Louise Bragg 25 0735 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 🗆 M 2 😾 F Days Hours NOWnth, 20 Year) 925 220-14-8292 MD 85 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director MD Harford Joppa 1 Yes 2 No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21085 USA 314 Powersby Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3X Widowed 4 □ Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker own home <u> 12th</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rose Knapp Thomas Bradley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11208 Bird River Grove Road Balto. Anthony Simonaitis /son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Holly Hill Cemetery 12/30/10 Baltimore MD 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Sign tu of Funeral Service Licenses Funeral Home of Essex 21221 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Ent.s. Underlying Due to (or as a consequence of) Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 WNo Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Highnown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 1 Yes 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 WNo HOSPIC ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident 1 Tes 2 No ☐ Acciden☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 3 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) 1040 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar KUMAR

2010

31. Date filed (Month, Day, Year) DEC 28

701

HARLES ST

SUITIS 6105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BOUNDS 5: 45 PM 2010 1ERVIN DECEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL NORTHWEST BALTIMORE RANDALLSTOWN 5. Social Security Number 8. Date of Birth (Month, Day, Dec 20 6. Sex Birthplace (State or Foreign Country)

MD **Funeral** 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 1 X M 2 - F Hours 78 MD 216-28-6174 Director Usual Residence of Decedent 28a-f shov 10b, County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Woodstock MD Baltimore 1 Yes 2 No 10g, Citizen of What Country? ò 10e Street and Number 10f. Zip Code 21163 "natural", or items 23a Funeral 10616 Davis Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) HVAC estimator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mervin Ray Bounds Annalee Hillman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $10616\ Davis\ Ave.,\ Woodstock,\ MD\ 21163$ permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Patricia Bounds (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 12-28-10 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Oxia 400764 d P.O. Box 195, Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CARDIOVASCULAR DISEASE ATHEROSCLEROTIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1No I ☐ Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 M No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Tes 2 No Accident Investigation 24 hours after deal Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: At the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Hurs—actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurs within 7 only one) 29b. Signature

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of

MURTUZA

31. Date filed (Month, Da

OLD

5401

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

M.D.

HUMED

2

D0060293

COURT ROAD, RANDALLSTOWN

DECEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Be1cher 3:45 PM William Edd Sr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Elderplus Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign cial Security Number **Funeral** June 12 1 XM 2 □ F Months Hours Min South Carolina Director 251-46-6780 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 Robinson Road 21146 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 ₩ Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Lee Parnell William Lee Belcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Belcher, Jr. / 14 Robinson Rd., Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 12/24/2010 Baltimore, Maryland Metro Crematory Inc 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ hypoxia days Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 L 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by lymphoma, CAD, MI, CHF, 1 Yes 2 No 3 Probably 4 Jnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISKA III ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier CRNP

Registrar

Bastern Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month ROSALIE 1850 PM 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ARROU MOSPITME LENTER CARROLL WETMINSTER Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 💢 F Days Hours Nov 5, 1938 Director 217-38-7667 72 Marvland Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County e filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Carroll Sykesville Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 912 North Avenue 21784 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2X No Specify: Specify: White Completed 3 Widowed 4 XDivorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) event, the Secretary Attorneys Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should le file Department of Health and Mental Important: If item 27 is mariled o John Boone Marie O'Donnell any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 North Avenue Sykesville, Maryland 21784 Ann Rieger, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 12/22/10 Baltimore, Maryland Signature of Funeral Service Voensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death RESPIRATORY Physician/ Notres Sympronia ALLITE disease or condition resulting in death) Medical Due to (or as a consequence of Examiner MEUNONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir PREUMONITIS The law requires that the death certificate be executed ASPIRATION Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation after death npleted filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide Medical 29a Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign re and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, MF MB P10029619 12.20.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore 1838 Greene Tree (Load - #420 31. Date filed (Mo Registrar's Signal State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month D. 2010 3:15p M Patricia Bennett December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Sykesville Fairhaven If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, pril 1 Days Hours 1 □ M 2 🖫 F Director 319-22-6792 14 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 72 hours after death with the Maryland Director Sykesville MDCarroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 7200 Third Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🚺 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) domestic homemaker other traumatic event, æ 18. Mother's Name (First, Middle, Maiden Surname) Vera Campbell 17. Father's Name (First, Middle, Last) George A. Doelle pe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2896 Hunt Valley Dr., Glenwood, MD 21738 1 and 2 s of Health item 27 Anne Contney (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 12-24-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee + Thigh Shapping P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 troke hemorrha Physician/ disease or condition resulting in death) Medical Due to (or as a consequent of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of 29b. Signature 29d. Date signed (Month, Day, Year) DODSCOL 110 12/23 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4Kesuille MO 21784 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

OHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #20a-c&22 Fer FH G910 12/28/10 JH
State of Maryland / Department of Health and Mental Hygiene
amend#19a&18 Per INF G916 6/14/2011 JH
Certificate of Death
Reg. No. 2 11 1 State Registrar Reg. No. 7 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Birmingham Dee-Day 13 2010 1925 M oan Medical 4a. Facility Name (if not institution, give street and number) 4 City, Town, or Location of Death 4c. County of Death **Examiner** Grove Rockville Montgomery Adventist Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
May 14, 1959 Social Security Number . Age (In yrs. last birthday) **Funeral** 9. Birthplace Hours 1 □ M 2 💢 F Poland Director 214-80-3633 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1235 Potomac Valley Road 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural" Completed Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname) **Bartelak**Julianna Bartelak 17. Father's Name (First, Middle, Last) မ Stanislaw Szymonik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Krzysztof Christopher Szymonik/brother 7219 Black Creek Lane Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XX remation 3 Removal from State Bayview Crematory, Inc Dec 30,2010 Baltimore, MD 4 ☐ Donation 5 📆 Other (Specify) Si manus of Euneral Service License Ron I Q S W timore 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Kaczorowski Funeral Home 1201Dundalk Ave. Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (ur as a consequence of) if any leading to inmedicause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician. The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ျု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D0062435 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who ca 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Day 24, 2010 Physician/ 10:25Am Bolesta Anthony Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Catonsville Charlestown RGS120 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Marwiland AMOT'19, 1914 96 Director 215-12-4920 Yrs. Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Catonsville Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. "natural", or items 23a 21228 719 Maiden Choice Lane HR345 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) & N Katz Store Manager 4yrs Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pelagia Bolesta မ Teofil Bolesta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 14605 Cutstone Way Silver Spring, Md. 20905 19a. Informant's Name/Relationship (Type, Print) David A. Bolesta Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of December 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Cem. 30, 2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee <u>Dundalk Avenue Baltimore.</u> Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ZOUS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has performed' 2 No the Hospital or Attending Physician; The 1 Tes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No ၉ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending death. 1 Yes Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Choice Lane Maiden Registrar's Signature State 2 Registrar

HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	laryland	-	rtment of F ctificate of i					
	-		Registrar 1. Decedent's Name (First, Middle, La	ast)		Cei	incate or i	Deali		Re Date of Death	g. No.	3. Time of Death
п	Physici		Florence T. Blaz							wonth cember	Day 2010	11:50 P M
2	/Medio Examin		4a. Facility Name (If not institution, gi)		4b. City, Town, o	r Locatio		James	4c. County of De	
-A			Broadmead				Cockeys				Baltimor	e
	Funeral		·	1 □ M 2 M □	ge (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours		Date of Birth Month, Day,	Year) 9. B	rthplace (State or Foreign Country)
	Director		149-05-4002 Usual Residence of Decedent		89	115.			Mai	. 31,	1921 Pe	nnsylvania
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation				_	10d. Inside City Limits
	a-fsh	ctor	MD Baltimor	e	Timor	nium						1 □ Yes 2 No
	with the Maryland a or 28a-f show	Jire	10e. Street and Number				10f. Zip Code			10	g. Citizen of What C	ountry?
	after death wi	Funeral Director	6 Thaxton Court				21093			11	USA	
	after dez or Items	nne	11. Marital Status	12. Was Decedent Armed Forces	?	. 13. \	Vas Decedent of H f Yes, specify Cuba	lispanic (an, Mexic	Origin? (Specify can, Puerto Rica	Yes or No- n, etc.)	14. Race - Am Black, Wh	
36	rs afte		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2 X If Yes, Give Year or Dates:		1	□Yes 2X No	Speci	fy:		Specify: Wh	ite
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28a-f show sht, the Medical Exa in we must be nouthed at	Completed by	15. Decedent's E		- 1	16a. Deced	lent's Usual Occup	ation		1	6b. Kind of Busines	s/Industry
215	be filed within 72 hortal Hygiene. id other than "natu event, Ira Medical	ple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	(Give life. L	kind of work done of NOT use retired	during m d)	ost of working	- 1		
2	ygien ygien er th	Sol	12	3		Regis	tered Nu				Nursing	
pu	be file	Be	17. Father's Name (First, Middle, Last	")							aiden Surname)	
yla	ould d Mer narke	ç	Peter Seder						nche Kat			
Ma	d 2 sl Ith an 17 is r traur		19a. Informant's Name/Relationship Charles J. Blaze				xton Cou				City or Town, State, 21∩03	ZIP Code)
ē,	tem 2		20a. Method of Disposition	ek / son			sition (Name of natory or other place		Date		0c. Location - City of	r Town, State
Baltimore,	Pages ent of nt: If i		f Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	9 (natory or other place Redeeme		12/30/20	010 B	altimore,	MD
alti	mit. F partm portai / inju		21. Signature of Funer U.S. rvi e Lice	1.1.22	riost		. Name and Addre			010 10		York Road
ä	permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, I'ms Once.		1000	My		Ru	ck Towson	n Fu	neral Ho	ome, I		on, MD 21204
п			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each	ed the death. line.	Do not ent	er the mode of dyir	ng, such	as cardiac or res	spiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	UP/	VE	MO	NIA					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque	ence of):						
		-	Sequentially list conditions,	b. Due to (or as	01-1	or the state						
	uted d insit	Examiner	Sequentially list conditions, it any, reading to innecliat cause. Enter Underlying Cause (Disease or injury that initiated events	500 10 101 5.	o cr o crasque	or idea or y						
Ć,	exec an and ial-tra	Еха	resulting in death) Last	Due to (or as	s a conseque	ence of):						
68760,	ifficate be executed g physician and as the burial-transit	edical	•	⊾ d								
	# © %	Med	IF FEMALE:									
Вох	death certific e attending pl id for use as t	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 🗀 Fetal (death 3 🗆	Ectopic pregnanc	;y			23d. Date of d Month	elivery Day Year
· 0	the a	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of de	eath 5∟	Other (specify) _					24,
σ.	w requires that the d s been signed by the should be detached		Part II. Other significant conditions	contributing to death	but not result	ting in the ur	nderlying cause giv	en in Par	rt I.	23e. Did toba	acco use contribute	to the cause of death?
of Vital Records,	puires n sign ild be	Completed by	DEMENT	IA						1 □ Yes	s 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4 ☐ Unknown
Ö	law req as bee 2 shou	lete	HUPERTEN	ISION)						24a. Was an		autopsy findings available
Be	The la ate ha page 2	d mo	77, 2							autopsy perform	prior to	completion of cause of
ital	lan: artifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Pla	ace of Death (Ch			2 140
>	Physiclan: this certific ral director,		1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 🗆 E	R/Outpatien	t 3 DOA Oth	er: 4 🗹	Nursing Home	5 ☐ Resider	nce 6 □ Other (Sp	pecify)
n	Ing Ifter	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D		28b. Time of Injury	28c. Injur Worl			Describe how	w injury occurred	
isic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	e ago Blood of In	iuru - At bon	no form etr	M 1 □	Yes 2		postion (Str	eet and Number or	Rural Route Number,
Division	lor A after Direc	ertif	4 Homicide determined	building, e	tc. (Specify))	set, factory, office			City or Town,		nural noute Number,
_	spita hours ineral y filler	aC		hysician: To the bes								
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification: To	(Check only 2 Medical Exa	miner: On the basis and manner s	of examination tated.	on and/or in	vestigation, in my o	opinion, c	death occurred a	t the time, da	ite and place, and d	ue to the cause(s)
_	To t To t	Σ	29b. Signature and title of certifier	P.	101	TX	29c. Licens	e numbe	er	29	d. Date signed (Mo	nth, Day, Year)
			Barbara	arr	M	IM	JU	28	342	•	10/0/	12010
			30. Name and address of person who	2 02 2	death (Item)	23a) (Type,	Print)	277	ph	CAL	4612	ILLE, MD
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signate	/ / 5	our ye	IKK	KD.	, we	REYSV	(m) (m)
	Registr		DEC 282010	Denne	A. ,	part	1					

DHMH 17 Rev 1/2001

17/33/10

BLALEK, FLORENCE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Crawford Leonard 2010 5:10p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 3908 Bateman Ave If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, Months Hours Min. **Director** 90 213-14-8929 NC Usual Residence of Decedent show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 □ No NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 U.S.A. 3908 Bateman Ave permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Montgomery Wards Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gertrude Johnson Pinkney Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3908 Bateman Ave, Baltimore, Md 21216 <u> Irene Crawford-Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baltimore National 12/28/2010 Baltimore, 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Eacility
March F/H West 0 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ tat ros Cancer disease or condition VNS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Dav Year Pregnant at time of death 2 No 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failune 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No penlip 1 Yes 2 No 25. Was case referred to medical 'examiner? 26. Place of Death (Check only one) 2 **N**O Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident 3 Suicide 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined.

Box 68760 Division of Vital Records, To the Hospital or within 24 hours a To the Funeral D

Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has eted filled in by the funeral director, page 2 v

Medical

29a. Certifier

(Check

only one) 29b. Signature 2

Registrar

DHMH 17 Rev 7/2009

State

cause of death (Item 23a) (Type, Print)

10N. Greene St

Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Turse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26817

Baltimore MD 2120

2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 8 2010 1:35 AM COCKRUM CARL **EDWARD** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES WALDORF GENESIS WALDORF CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, CT. 24 Months Days Hours Min WEST VIRGINIA Director 1932 <u>578-40-4748</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No CHARLES WALDORF MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10398 CASSIDY COURT 20601 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 △Yes 2 ◯ No ARMY
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Divorced 4 Divorced BLACK Completed Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12TH \end{array}$ College (1-4 or 5+) SKY CAP PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ANNA MAE ANDERSON SHELTON COCKRUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troone. <u>LINDA COCKRUM/WIFE</u> 10398 CASSIDY COURT WALDORF, MARYLAND 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from CHELTENHAM, MARYLAND 4 ☐ Dopation 5 ☐ Other (Specify) MD VETERANS CEMETERY 12/27/10 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death FAILURE TO THRIVE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi DIABETES MELLITUS and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical CEREBRAL VASCULAR DISEASE IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Pregnant at time of death 2 No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Ph sician/

21215-0036

Baltimore, Maryland

P.O. Box 68760

Records,

Division of Vital

Completed by Be 25. Was case referred to medical ည

Certificate:

Medical

examiner?

1 🗌 Yes

27. Manner of Death

1 XNatural

Accident

Suicide

4 Homicide

2 **X**No

5 Pending

Investigation

determined

6 Could not be

autopsy performed

Yes 2 X No 26. Place of Death (Check only one)

1 ☐ Yes 2x No

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28c. Injury at work? 1 🗌 Yes 2 🗌 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2103

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

28a. Date of injury

(Month, Day, Year)

12070 OLD LINE CENTER # 302 WALDORF, MARYLAND 20602

State Registrar

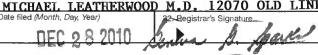
filled in by

completed

24 hours a Funeral L

within 2 To the I

Date filed (Month, Day, Year)



DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Eula Crawford 10:10PM 7-010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 5. Social Security Num **Funeral** If Under 1 Year rs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀F (Month Day Yes Country) 214-30-6872 Director 83 MD Usual Residence of Decedent 10b. County pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔯 No Baltimore Halethrope 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 923 Imperial Court 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th Homemaker Damestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Anna Smith Herbert Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Brown/Son 750 Changing Seasons Road, Westminster, Md 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans 1-4-2011 Owings Mills, MD 22. Name and Address of Facility Wylie Funeral Forme P.A. of Baltimore Co. 21. Sign ture of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Pao 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition (Oscherati Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a conservience of been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 1 ☐ Yes 2 🗷 No death? of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Division 1 Yes 2 No Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicion To the basis of my knowledge, death occurred at the fine, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of qertifier 29c. License number 3306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nellie Μ. Month 2010 Cook 20 Dec. 9:30a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 802 Bengies Road Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XCX Days Hours Min. Country) 234-32-3438 Director 86 Yrs. Aug. 7. 1924 WVA Usual Residence of Decedent 28a-f show 10b. County at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Baltimore Middle River 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 802 Bengies Road 21220 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o, þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 X Widowed 4 Divorced Specify "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Clerk Martin Marietta Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ottman B. Goodwin Ada Stoneking 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobbie Seidel /daughter 16981 Lutz Road Stewertstown PA 17363 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12/21/10 Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Fuenral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Deat Physician, disease or condition resulting in death) anco un Medical Due to (or as a consequence 1) Examiner Sequentially list conditions, in any, leading to intringulate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal usa 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident 🗆 Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gentifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 122 on John LOL Mace Aus.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

1124

32. Registrar's Agnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 Kestutis G. Chesonis December 2:20 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 108 Elmwood Road Baltimore N/A Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 X M 2 D F 0170271942 68 Yrs Lithuania Director 219-38-1354 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified N/A MD Baltimore 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? be Funeral ral", or items 23a Examiner must b 108 Elmwood Road 21210 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Research Lab Dept. of the Army Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of the second of the seco permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. 2 Antanas Chesonis Felicia Narusis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Garliauskas (Spouse) 108 Elmwood Road, Baltimore, Maryland 21210 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 12/29/2010 4 Donation 5 D Other (Specify) Baltimore, Maryland na ure of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final METAGINTIL nosTATE Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, nei if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🗌 No Director: After this certificate has been signed by the and in by the funeral director, page 2 should be detached Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 2 N 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. DateIsigned (Month. Day, Year) Music 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STruck 150/TIMORR (Ano 31. Date filed (Month, Day, Year) Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22^{pay} Dec. Richard Conley 20**1**0 7:32 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day Ye Mar 26, Birthplace (State or Foreign Country)
 Tdobo **Funeral** .Year) 938 1**X** M 2 □ F 519-38-3106 72 Yrs **Director** Idaho Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 208 Severn Drive 21401 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cabinet Maker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked or ೭ Frank Conley Ora Hackworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per mit. Page 1 and 2 sh Der artment of Health ar Important: If item 27 is any injury or other trau Karen Conley / Ex-Wife Elliott Rd., Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 12/23/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 <u>A</u>lyson K Taylor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 Vo
9 Unknown Pregnant at time of death Month Day Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 Other 1 🗌 Yes ျှ 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No 1 Natural 2 Ccident 5 Pending 24 hours after death. Funeral Director; A Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Ам

Records, Hospital or Attending Physician: The law Division of Vital

P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of cert

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert T Peterson, 600 Ridgely Avenue,

MD

Annapolis, MD 21401

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible

			For State	State of M	arylar		artment of I	Health and	Mental H			40784
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	tificate of I	Jeath	0.000.40	Reg. No.		+0104
ا بر	ysicia Medic	al	Albert 4a. Facility Name (if not institution,	Joseph		Col	Lombo			eath per 24,	2 01 0	3. Time of Death 6:56 P M
	camin	er	10101 Grosvenor	Place #215				Bethesda	l		nty of Death tgomer	у
Dire	neral ector		078–18–6633 Usual Residence of Decedent	6. Sex 1 M 2 F	85	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		ay, Year)	9. Birth Coun New	olace (State or Foreign stry) York
land	dat	tor	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					0d. Inside City Limits
Mary 28a-f	otifie	Funeral Director	Maryland Montg	omery	No	orth Be	thesda					1 ☐ Yes 2 🏝 No
th the	t pe u	al D	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	ntry?
ath wi	mus	nue	10101 Grosvenor				20852			United	State	es
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho	event, the Me Ical Examiner must be notified at	Completed by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marrie3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 🛎 Yes 2 🗌 If Yes, Give Year or Dates. V	No	H	Vas Decedent of H Yes, specify Cuba		Specify Yes or No rto Rican, etc.)		Race - Americ Black, White, e hify: Whit	etc.
15-(72 hou 1 "nat	le Jica	ple	15. Decedent (Specify only highes	's Education t grade completed)	- 1	16a. Deced	ent's Usual Occupind of work done of	ation	orkina	16b. Kind of	Business Inc	dustry
vithin iene.	th th	S	Elementary/Seconday (0-12)	College (1-4 or 5-	+)	iire. DC	NOT use retired) ftsman	, , , , , , , , , , , , , , , , , , ,	orning	Floor	mia Ca	
land in the filed vertical Hyginsked other	vent,	Be	17. Father's Name (First, Middle, La			DIE	T CSMAII	18. Mother's N	ame (First, Middle,		ric Co	ompany
Marylance of 2 should be file salth and Mental H 27 is marked o	atice	잍	Frank Colomb	0_					Vaccaro	iviaideri Surria.	rrie)	
Mar shou and rism	ran		19a. Informant's Name/Relationship			19b. Mailin	g Address (Street a	and Number or F	ural Route Numbe	er, City or Town	, State, Zip C	rode)
	thert	-	Paul M. Colombo	/ Son			Barkwate:	r Court	Bethesda	a, Mary	land 2	0817
Baltimore, bermit. Page 1 and Department of Hea	yoro		1 X Burial 2 Cremation 3	Removal from State	0	lace of Dispos emetery, crem	atory or other place	e) Dece	Date ember	20c. Location		
Baltimo permit. Page Department of	/ injur	ł	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Lic	-	Pari		orial Parl	29.	2010			Maryland
n abe	an ou		> Kety 7 1	tuy MO16	07	R	obert A. 00 W. Mor	Pumphre	y Funera	1 Home	Rockv	ille, Inc. and 20850
Prysici Med Examí	ical iner	iner	23a. Part 1. Enter the disease, or or shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	y one cause on each line.	ary A	n. Do not enter Artery ence of):	the mode of dying	a, such as cardía	c or respiratory ar	rest,		Approximate Interval Between Onset and Death 24 Years
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, gage 2 should be detached for use as the burial transit		edical Examiner	cause. Enter Underlying Cause (Disease or Imjury that initiated events resulting in death) Last	cDue to (or as a	consequ	ence of):						
that the death certific			FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	☐ Fetal	death 3 🗌	Ectopic pregnancy Other (specify)				ate of deliver	y Day Year
s that igned l	5 1	ξ G	Part II. Other significant conditions	contributing to death but	not resu	Iting in the und	derlying cause give	n in Part I.	23e. Did to	bacco use con	tribute to the	cause of death?
requires been signatured		- E							1 🗆 1	es 2 X No	3 🗆 Proba	ably 4 🗆 Unknown
in: The law rificate has b		najaidiiio a	5. Was case referred to medical	T					24a. Was a autop perfor 1 Yes	sy med?	Were autops prior to comdeath?	y findings available pletion of cause of
ysiclan: is certific director,	1 G	וב	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	2 🗆	P/Outpationt	041	e of Death (Che				
tending Ph death. tor: After th			7. Manner of Death 1 🔀 Natural 5 🗌 Pending 2 🗍 Accident Investigati 3 🗍 Suicide 6 🗎 Could not	28a. Date of injury (Month, Day, 1	(ear)	8b. Time of injury	28c. Injury a work? M 1 1 Ye	4 L Nursing F	lome 5X Residence 128d. Describe ho			
tal or A	2		4 Homicide determine		- At hom Specify)	e, farm, street	, factory, office		28f. Location (Si City or Town	reet and Numb n, State)	er or Rural R	oute Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completed filled in by the fune	Medical		only one) 3 Certifying Nu	ysi⊏ian: To the best of my niner: On the basis of exar rse Practioner: To the be								e(s) and manner stated.
V wit		29	9b. Signature and title of certifier	00			29c. License n			9d. Date signe		
		2/	Name and officer at					4059		Decen	nber 2	7, 2010
	State	81	D. Name and address of person who Geeta Raja, M.D. Date filed (Montua), page 2		าพดด	i Road.	Suite 1	00 Beth	esda. Ma	ryland	20817	
Regi	strar	1			10	7	7-54					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 3:15 Rita Milena December Αм Colaianni 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Yea April 20, 5. Social Security Number 7. Age (In yrs. last birthday Year If Under 24 Hrs. 9. Birthplace (State or Foreign Min. 1 □ M 2 🛭 F Hours . 1938 Washington, D.C 579-50-2073 72 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 🕅 No North Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6309 Windermere Circle United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc 1 Never Married 2 X Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Malinda Fornili E. Michael Roll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6309 Windermere Circle, N.Bethesda, Maryland 20852 Joseph V. Colaianni / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 □ Donation 5 ☒ Other (Specify) Entombment Gate of Heaven Mausoleum 29, 2010 21. Signatur- of Fundinal Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Market Bro land 20850-2805 MO1305 Approximate Interval Between 7 Years

permit. Page 1 and 2 should be f. Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Ph_sician/

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

ıral", or items 23a or 28a-f shov Examiner must be notified at

"natural".

should be filed withir and Mental Hygiene is marked other tha

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical **Examiner** Examinet

attending physician and for use as the burial-tran after death.

Director: After this certificate

Physician/Medical

þ

Completed

To Be

Certificate:

Medical

Accident Suicide

4 Homicide

only one)

3 29b. Signature and title of certifier

Nelson Kalil,

31. Date filed (Month, Day, Year)

29a. Certifier

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

6 Could not be

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

AIANNI,

Vrappallerivi	300 West Montgomery Avenue, Nocky	TITE, HALYTAIKI 20030 2003
	r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespin only one cause on each line.	Interval Between
Immediate Cause (Final disease or condition resulting in death)	a Chronic Lympholytic Leukemia	7 Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):	
Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequence of):	
	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No g □ Unknown	23c. If yes, outcome of pregnancy 1	23d, Date of delivery Month Day Year
Part II. Other significant conditi		es 2 🔀 No 3 🗆 Probably 4 🗀 Unknown
	24a. Was ar autops perform 1 □ Yes 2	y prior to completion of cause of ned? death?
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Reside	nce 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of injury at work? 28d. Describe ho	w injury occurred

work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815

29c. License numbe

D51616

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

29d, Date signed (Month, Day, Year, December 22, 2010

Registrar

State

within 24 hours a

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010 Day 22 **Physician** CROM LEIGH 12 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE MARLEY NECK BURNIE GILEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1/30/1922 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min 1 M 2 TYP Connecticut **Director** 044-14-6481 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State d other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Md. Anne Arundel Linthicum 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 511 Dogwood Rd. 21090 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examinat once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Albert Matilda Bauman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jody McCullough /daughter 511 Dogwood Rd. Linthicum, Md. 21090 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Hanover, Md. 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory Inc. 12/23/2010 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Litensee 4112 Old Columbia Pike Ellicott City Md. 21043 MOO845 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. PNEUMONIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been staned by the attention inhorising and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🗖 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058580 12/22/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bal Hanu. 3233 SUFERIOR LN, 821. SUPERIOR LN BOWIE MD

Registrar

State

31. Date filed (Month, Day, Year)

2

10-09338

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

usan Clendenin	State of Maryland / Department of Health and Mental Hy 1-For State Certificate of Death		2010 g. No.	40787
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	Date of Death Month		3. Time of Death
Medical Examine	Susan Clendenin	December	5, 2010	0132 hrs
)	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace		4c. County of Death Harford	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Birth		hplace (State or
Director	218-68-5786 1 M 2 F 57 Yrs. Months Days Hours Min.	1	Foreig Cou	west
	Usual Residence of Decedent	I Aug 7,	1953	Virginia
yae /	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
faryland 28a-f show Lat once.	MD Harford Churchville			1 Yes 2 No
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a nr 28a-f sho traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 21028	10	g. Citizen of What Cour USA	itry?
ith the 23a n notifi		anife Van at Na		an Indian Black
or items 23 must be no Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	call illulali, black,
	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: Whi	te
ours aft atural" samine	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use retired.		16b. Kind of Business/I	
6 na 72 h	Elementary/Secondary (0-12) College (1-4 or 5+)		Harford M	lemorial
5-0036 ed within 72 hour stygiene. other than "natu the Medical Exan Completed	12 0 public broadcast opera		hospital	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO Be Complé		/ictoria		
212 ould bould by Ment s mark fic ever	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			Zip Code)
MD ad 2 should and 2 is and 27 is and 27 is	James Clendenin/spouse 312 Calvery Road Chur	chville		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by I	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Page Page nent o	4 Donation 5 X Other Specify: in State			
Baltimore, permit. Pages la u Department of Hei Umportant: Uffer injury or other tr	21. For the re of Funeral Dervice Licens 22. Name and Address of Facility. State Anatomy Boar	cd 655 W	. Baltimore	Street
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	r respiratory arre	st. shock, or heart	Approximate Interval
Physician /Medical	fature. List only one cause on each line,			Between Onset and Death
zaminer	Immediate Cause (Final disease or condition resulting in death) a. Narcotic (Oxycodone) Intoxication Due to (or as a consequence of):			
	Sequentially list conditions, b			
ir eric	if any, leading to immediate Due to (or as a consequence of):			
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Box 68760, he death certificate be executed by the attending physician and hed for use as the burial - transit Physician/Medical Exc	MX UNPENDED AMENDED 23a,27,28a-f per me g915 5-4-1	1 vt		_
60, ate be hysici e buri	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
6876 ertificate ding phy e as the b	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specific)	incy	Month D	ay Year
D. Box (the death ce by the attend tohed for use Physicia	1 Yes 2 No 9 V Unknown 9 Unknown			
D. B tribe de by the ached i	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
ires that the signed by signed by 1 be detach		1 Yes	2 No 3 Prob	ably 4 Unknown
ords * requi s been should		24a. Was a autops		topsy findings available ompletion of cause of
Records, The law require, ficate has been signage 2 should be Completed		perform 1 Yes 2		s 2 No
Vital Recysician: The I his certificate I director, page	25. Was case referred to medical 26. Place of Death (Check examiner?			
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been seled in by the funeral director, page 2 should be refification: To Be Completed.	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Sure 4 Nursin		Residence 6 Other	
n of ding Ph.h. After t funeral	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 1 Yes 2 No	_	. ,	
ivisior or Attendather death Director: Jin by the	2 Accident Investigation 10 12-14-10 10 3:07 pm 28e. Place of Injury - At home, farm, street, factory, office building, etc.	unknow 28f. Location (S		rat Route Number, City
Division o spital or Attending rours after death. Beral Director: After filled in by the fune Certification:	Suicide Suicide Suicide Solution of be determined (Specify) found in car	Blvd A	_{ate)} 1109 S. berdeen, Md	ral Route Number, City Philidelphi •
8 4 2 5 9 E	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause	e(s) and manner as state	ed.
To the Ho within 24 To the Fu completel	one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date a		
T T S	29b. Signature and title of certifier 29c. License number		29d. Date signed (Moi	
	Way site The Yell O.C.M.E.		December 5, 201	
	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD.	21201		
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Registra	11-1: 9 8 7010 / maria st. Laure			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Casale 26, Margaret Catherine Dec. 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Franklin Woods Nursing & Rehab. Rosedale Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 □ M 2**X** F Months Davs Hours March Day Year 911 Director 99 Yrs 170-18-3881 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD **Baltimore** Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1759 Melbourne Road 21222 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XX No Specify: Specify. Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmission. Clothing College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing Seamstress 10 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Catherine Spada Salvatore Azzarello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Mrs. Mary Franz (Daughter) 1759 Melbourne Road Dundalk, Maryland Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Gardens of Faith Cem, 12/30/2010 Baltimore, Maryland Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee ²² Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Hypertensive Atherosclevita Carlovascolar Discor disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Pregnant at time of death Month signed by the a 1 Yes 2 4 a 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Dementic Completed 24a, Was an Jas page performed certificate 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury thin 24 hours after death. the Funeral Director: After impleted filled in by the fun Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Butimere

3. Time of Death

9. Birthplace (State or Foreign

White

21222

Approximate Interval Between Onset and Death

Dav

Year

10d. Inside City Limits

1 Yes 2 No

Baltimore

Italy

10:30 AM

Registrar DHMH 17 Rev 7/2009

State

Perins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pur.

31. Date filed (Month, Day, Year)

39helee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10:50 PM Lula G. 1) ecember Daughton 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hartor itizens Nursing Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 M 2 XF Months Days Min. Hours Country)
Maryland **Director** Yrs 218-16-9515 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 S. Parke St. Apt. A2 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) In home 11 Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Wilson Bedwell <u>Mary Margaret Story</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellis (daughter) Diane L. 3330 James Run Road. Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) R.A.Ferris & Company | 12 28/2010 | West Chester, PA 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licenses Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death dration Physician. Medical resulting in death) Due to (or as a consequence Examiner 04165 Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral injector, page 2 should be detached for use as the buriar-transit completed filled in by the funeral director, page 2 should be detached for use as the buriar-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ almetal 184 Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsv performed Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) Willian Name and address of person who completed cause of death (Item 23a) (Type, Print) evolution St- Harrese 11 ham Mp Kamnydu HOG K

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

9

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Physician/ 2 Medical or Location of Death 4c. County of Death **Examiner** Haltimore Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral Director** 23a or 28a-f shov 10d. Inside City Limits Examiner must be notified at Director Yes 2 □ No 10f. Zip Code 2/2/8 10g. Citizen of What Country? Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 2 XNo Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) District Be 20b. Place of Disposition (Name of 1 X Burial 2 ☐ Cremanon — 4 ☐ Donation 5 ☐ Other (Specify) Burial 2 Cremation 3 Removal from State 21. Signature & Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final EMEN Pnysician disease or condition resulting in death) Medical **Examiner** CEREBROVAS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical 6f Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 2 Accident 5 Pending Division Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EUTAN ST 4500 BALTIMONE MA LINI 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death December 26 Physician/ 2010 3:12 P M Eileen E. Dettler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Baltimore 4434 Cedar Garden Rôad 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Davs Hours 0193794937 Marvland 213-32-0626 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director N/A Baltimore 1 ☑ Yes 2 ☐ No MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ò Funeral items 23a 21229 United States 4434 Cedar Garden Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 ☐ Widowed 4 ☐ Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Services Store Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ပ Gertrude Hartman Louis Sidire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6260 Richie Drive, Mount Airy, Maryland 21771 Robin L. Radoci (Daughter) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) permit. Page
Department o
Important: If
any injury or
once. injury or 4 Donation 5 Other (Specify) Meadowridge Memorial: 12/30/2010 Elkridge, Maryland Aign ture of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiac Physician Sudden disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** oron am Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit or Attending Physician: The law requires that the death certificate be executed inbete Due to (or as a consequence of) resulting in death) Last the attending physician the for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year signed by 23e. Did tobacco use contribute to the cause of death? Ś tailure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? pulmonan 24a. Was an has 1 Yes 2 No After this certificate 1 Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1 🗌 Yes 2 🗍 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McCurdu

28 2010

29c. License number

716 Maiden Choice Lane Suite 101 Baltimore, Maryland

D25861

29d. Date signed (Month, Day, Year)

2010

12/27

Division or Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001

Copper Ridge
32 Registral's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> Folis

28

31. Date filed (Month, Day, Year)

710 Obricht Rord Sykyville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DECEMBEN Day Year 21 2 010 HARRY DASCH 23:40M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death LOCH PAVEN BATTIMORE 5. Social Security Number 6. Sex 7. Age (Irı yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day March 2 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Hours Min. Maryland Director 212-44-1977 Yrs 1945 65 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Madical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 2917 Salisbury Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Å Yes 2 ☐ No If Yes, Give Vietnam Year or Dates Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Local #16 12 Years Iron Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Doris Hill Harry J. Dasch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 Salisbury Ave. Edgemere, MD 21219 Mrs. Paula M. Dasch (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ <u>Cr</u>emation 3 ☐ Removal from State Crownsville V.A. Cem. 12/28/2010 4 ☐ Donatjon 5 ☐ Other (Specify) Crownsville, MD permit. 21. Signat f Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Wise Ave. Dundalk. Marvland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PROSTATE CANCER Physician/ METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Examin burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the h attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month the detached 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MELLITUS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown ARTERIOSCLENOTIC CARDIOVAS CULAT DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S- MILLEN 3900 LOCK PAVEN BULLEVARD. 31. Date filed (Month, Day, Year) 32. Projetrar's Signature State DEC 2 Registrar

29a. Certifier

only one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D30272

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 23. Joseph Darrell, M.D. 2010 John 7:05am [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min. Sept. 11. 1 🔀 M 2 🗆 F 84 220-18-9800 MD **Director** Usual Residence of Decedent show 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Baltimore Owings Mills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 306 Wyndham Circle Unit E 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 X Yes If Yes, Give Completed by 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Medical Doctor Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Darrell Catherine Foerkolb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Lou Darrell (Spouse) 306 Wyndham Circle Unit E, Owings Mills, MD 21117 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 💯 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Family Cemetery 12/29/2010 Randallstown, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or residency arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 24 hours after death. **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

Registrar

Box 68760

Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

040350

MUND #205. OWNES MICLS,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7.50 PM Physician/ LISEN HARDI DHN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Season's Hospice 5. Social Security Number Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 85 Months Days Hours Min. Oct. 17, 1925 Maryland 219-10-0115 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2X No Baltimore Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 9 United States "natural", or items 23a Funeral 21227 930 Circle Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Xyes 2 No Navy Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirance. þ Baltimore, Maryland 21215-0036 White 1 XYes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Montgomery Wards Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Virginia Banks John H. Eisenhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 930 Circle Drive, Baltimore, MD 21227 Shirley A. Eisnehardt - Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Atlantic Crematory Dec.28,2010 Glen Burnie, MD 4 Donation 5 □ Other (Specify) 22. Home and Address of Facility Ambrose Funeral Home, Inc. 21. Sign 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Uncertying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed a No 1 🗌 Yes 1 ☐ Yes 2 ☐ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be LNPATIENT Hospital Other: 2 No 1 Yes ြု 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar

suell

ASNEEM

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mi

2835

mi

Registrar's Signa

128296

SMITH AVE, BALTO

amend #205 Rer RH E911 1/03/2011 THealth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Catherine Eline Dec. 26^{pay} 2010^{ear} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Co. Riverview Nursing Center Essex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day Year) une 25,1930 1 M 2 TXF Days Hours Min. Director 213-28-8414 80 June Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Oakwood Road United States 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ▼No Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 Years College (1-4 or 5+) Gas & Electric Co. Typist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Oscar Werner Elizabeth Lorch 19a. Informant's Name/Relationship (Type, Print)
Mark Eline (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 179 Gode) 1894 August Ave. Dundalk, Maryland Mark Eline Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/4/2011 Crownsville, MD 21. Signature of Funeral Service Licensee Dadar Rucker Futter al Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Physician/ Atrial Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate has funeral director, page 2 s 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Investigation Natural work? nours after death.

neral Director: After dilled in by the fur 2 Accident
3 Suicide
4 Homicide 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

White

21222

Onset and Death

Day

29d. Date signed (Month, Day, Year)

Year

1 Yes 2X No

Maryland

3:50 A M

within 2.

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

SEBASTIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20/42

State Registrar

DHMH 17 Rev 7/2009

Easter,

3023

32. Resistrar's Signature

002217

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:4SAM athleen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Hookins Burlew Care Contr If Under 1 Year If Under Months Days Hours Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreig **Funeral** Days 1 □ M 2 🔀 F (Month, Day, Year) ug. 16,1947 Country) 206-38-8212 Director PA Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Edgemere 1 Yes 2 No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7603 Winsor Avenue 21219 United States "natural", or items death . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Retail 12 Years Salesperson Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosetta Spencer George Leggore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7603 Winsor Ave. Edgemere, Maryland 21219 7603 Winsor Ave. Mr. Bernard H. Elways (Husband) injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 12/29/2010 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature V Funeral Service Livensee Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Aorto ilias DOOKS Medical resulting in death) Examiner Peri Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit Gangrene and attending physician Physician/Medical lears that the death certificate be Failure as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months? o Day Pregnant at time of death Month Year ed by the a 9 Unknown P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. been signed to should be deta 23e. Did tobacco use contribute to the cause of death? by Records, The law requires DISECTOR 12 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No Division of Vital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completed filled in by the fi death. Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D04383 December 23, 2010 5505 HOPLINS Bay view Circle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD ee no 3 21224 BAIT I mare 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

17

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Norman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29tate of Maryland 10 epay 2892016 dealth and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Helen Anna Ferrell December 7:10 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Cockeysville Furnace Court 8. Date of Birth May 9, 1930 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 🗌 M 2 🖵 F 80 Maryland **Director** 214-24-0816 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2√√2 No MD Ocean City Worcester 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21842 134th Street 406 Apt. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify. Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Residential Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anthony Ena Agatha Santoni 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11607A Windward Drive: Ocean City, MD 21842 son Frank E. Ferrell 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Di Burial 2 Digrer 20c. Location - City or Town, State remation 3 - Removal from State Dulaney Valley Mem Gardens 12/23/2010 4 Donation 🛮 Other (Specify) Timonium, MD 22. Name and Address of Facility York Road 21. Signature of Fun kuck Towson Funeral Home, Inc.. Towson, MD 21204 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MONTHS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 6X Other (Specify) Hers home 2 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 24 hours after death.

Funeral Director: After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 29c. License number 29d. Date signed (Month, 112/21/2010 se of death (Item 23a) (Type, Print) 30. Name and address of son who completed car FALLSRD SUITE 200 J. SEIFTER, M 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

Registrar

10-09887 Sylvia Fitzgerald Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sylvia Fitzgeraid	1- For State Registrar			t of Health and Menta of Death	ai Hygiene 	2010 No.	+0800
Physician Medical Examine		First, Middle,Last)	Fit	zaerald	2. Date of Death Month D December 2	yay Year 12, 2010	3. Time of Death 1959 hrs
	4a. Facility Name (if n Harbor Hospit	ot institution, give street and n	umber)	4b. City, Town, or Location of Baltimore		4c. County of Death	
Funeral Director	5. Social Security Num		7. Age (In yrs. last birthda		24Hrs. 8. Date of Birth(MM/DD/YYYY) 9, Birtl O 1971 Foreign Cou	
nd show any ice.	M	ecedent b. County	10c. City, Town or i				10d. Inside City Limits 1 Yes 2 No
h the Maryland 3a nr 28a-f sh totified at once		orndale Av	e. Apt. 3	10f. Zip Code 21215		Citizen of What Coun	try?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f show injury nr other traumatic event, the Medical Examiner must be notified at once. To Be Commissed by Furneral Director			Forces?	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I		14. Race - Americ White, etc. Specify: BIA	ean Indian, Black,
5-0036 ed within 72 hours tygiene. Inher than "natur the Medical Exam	15. Decedent's Educ Elementary/Second	cation (Specify only highest gra lary (0-12) College (1-4 or 5+) duri	edent's Usual Occupation (Give ki ng most of working life. DO NOT u VEN WORKED	se retired)	6b. Kind of Business/Ir	dustry
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	James	Fitzgerald	19h M	18.Mother's ROSA ailing Address (Street and Numb	Name (First, Middle, Main Harris	·	Zin Codo)
MD 21 d 2 should d 2 should Ith and Me n 27 is ma numatic er	larnisha	Fitzgerald	-Sisterinlaw	712 Melville	Ave. Balto	mo 21218	3
iges land of Hea		Cremation 3 Removal fi	rom State crematory	sposition (Name of cemetery, or other place)		Oc. Location - City or 1	
Baltimore, permit. Pages I a Department of He Impurant: If ite	4 Donation 5 21. Signat of Funer	Other Specify:	1/YH. ZIG	n Clmetery 22. Name and A. 2 - 2 of Facility 22. To Fredni ton	Funeral Hor	ansdowne me P.A.	mo
Physician /Medical examiner		one cause on each line.	aused the death. Do not er	ter the mode of dying, such as car exication (Metha	diac or respiratory arrest,	, shock, or heart	Approximate Interval Between Onset and Death
	or condition resulting i Sequentially list condi if any, leading to imme	itions, b	a consequence of):				
ted Insit	cause. Enter Underlyi (Disease or injury that events resulting in dea	ing Cause t initiated ath) Last C. Due to (or as a	a consequence of):				
60, nte be execut hysician and e bunal - tran	X UNPENDED	dd	27, 28a-f pe	r ME G911 1/11/	11 MAM		
ox 687/eath certifice attending ploor use as the	IF FEMALE: 23b. Was decedent pre past 12 months? 1 Yes 2 No	egnant in the 23c. If yes,	outcome of pregnancy birth 2 nant at time of death 5		pregnancy	23d. Date of delivery Month Da	ay Year
ires that the de signed by the detached if be detached if		ant conditions contributing to	o death but not resulting in	the underlying cause given in Part		cco use contribute to the	
tal Records, cian: The law require certificate has been sigector, page 2 should b				C Plane of Dorth (C	24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
1 of Vital Recting Physician: The I. After this certificate I funeral director, page	1 Yes 2	41	Inpatient 2 ER/Outpa	26.Place of Death (Cotient 3 DOA Other, and a position of Injury 28c. Injury at Work?		sidence 6 Other:	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the nours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P.	1 Natural 5 2 Accident 3 Suicide 6	Pending $fd.1$	n, Day, Year) 2/22/10 fd.7 se of Injury - At home, farm,	:35pm 1 Yes 2 X N street, factory, office building, etc.	unk. 28f. Location (Stre	et and Number or Rura	5.23
Divis To the Hospital or a within 24 hours after To the Funeral Division completely filled in IMMedical Certifit	29a Ceruner .	ertifying Physician: To the bes	st of my knowledge, death of examination and/or investor	occurred at the time, date and place stigation, in my opinion, death occu	e, and due to the cause(s) and manner as stated	
E E E S	Mel	e of certifier La Beasall	(Wo	29c. License number O. C. M. E.		9d. Date signed (Mont December 23, 20	
	Melissa Brass		dical Examiner 11	1 Penn Street, Baltimore,	MD 21201		
State		Day, Year) 32. Re	gistrar's Signature	had I			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Dec_ 4:00 A M Helen Mary Faber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4156 Louisville Road Finksburg Carrol] Social Security Number 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthpia Country) NY **Funeral** 1 □ M 2 👽 F Months Davs Hours Min (Month, Day, Year) July 15. Director 83 123-20-0799 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f 1 🗌 Yes 2 🙀 No MD Carroll Finksburg 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 4156 Louisville Road 21104 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give X 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. White Specify 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I marked o عود and 2 shc. • of Health and M • tem 27 is marke. • er traumatic ev ပ Gustav Goerger Anna Whiting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan Cooke (Daughter) 4156 Louisville Road, Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once. 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12126/10 All County Cremation Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service License MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death pulmone Ph_sician/ obstructive HYONIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to humoulate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to for as a consection of cf) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for i in the past 12 months?

1 Yes 2 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2XNo Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Hospital or Attending P 24 hours after death. Funeral Director: After t Certificate: 28d. Describe how injury occurred injury 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 🗌 Could not be 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one 29b. Signature are till December 24 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Rumb 645 Libert

HMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)
DEC 28 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Μ. Doris Freeman 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Homewood Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1 □ M 2 🛣 F Months Hours Min Director 217-24-1697 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be 23a Funeral 1400 E. Madison St. Apt 201 21205 items. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 0 ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give "natural" Specify. Completed 3 Widowed 4 Divorced Black Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Days Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tva permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. William Role 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn White/Cousin 3003 Ε. Baltimore St.Baltimore Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Trinity Cemetery Dec29,201 Balto. Md Signature of Funeral Service Linesee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME PRESTON ST BALTIMORE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final ementa Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or imjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Ď 4 Pregnant
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death the detached 9 Unknown as been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an Jas , page 2 autopsy certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? 2 MNo Hospital: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Do069314 30. Name and address of person wh

Registrar DHMH 17 Hev 7/2009

State

31. Date filed (Month, Day, Year,

son who completed cause of death (Item 23a) (Type, Print)

ham woods per Parkville MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Martin Fratta Dec. 2010 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Edgemere Baltimore Co. <u>17 Barbara Lane</u> 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Hours Nov. 11, 1922 215-14-9406 Maryland Director 88 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits death with the Maryland Funeral Director Baltimore Edgemere MD 1 ☐ Yes 2 ☑ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 17 Barbara Lane United States 21219 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1X Yes 2 No within 72 hours after 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Superintendant Manufacturing Be (Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Teodore Fratta Erminia Tosches 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Barbara Lane Edgemere, Maryland 21219 Mrs. Theresa Fratta (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Service Corp. 12/27/2010 Towson, Maryland e of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ FROME disease or condition resulting in death) Medical Examiner EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): The law requires that the death certificate be executed burlal-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No Yes 2 Division of Vital Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: in 24 hours after deaun. he Funeral Director, After this of maleted filled in by the funeral dire 2 XNo Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29h. Signature and title of certifier 101 ss of person who completed cause of death (Item 23a) (Type, Print) 2300 31. Date filed (Month, Day, Year) State Registrar

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should and Me is mar raumati		19a. Informant's Name/Relationshi	01								er, City or Town, Baltin			2121
and 2 Health tem 27		Shantivia Br 20a. Method of Disposition	own-Daugh	20b. Plac	ce of Dispo	sition (Name o	of			ate	20c. Location			
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	edical	(Check 2 Medical E	Physician: To the best of aminer: On the basis of e	examination a	and/or inves	tigation, in my	opinior	n, death oc	curred at	the time, date	and place, and d	ue to the ca	use(s) and m	anner state
To the within To the compl-	Σ	only one) 3 🗆 Certifying 29b. Signature and title of certifier	0 0	w ?		29c I	icense	number			29d Date sign	ed (Month.	Dav. Year)	2011
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		30. Name and address of person v	CRUZ	M.	7	13	ON	50	ECC	OURS	5 170	12/2/	(AL	

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Graham Gregory 20°10 Dec. 9:05A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Min. Hours 12-06-53 57 Director 214-62-7907 MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral The Alameda 2906 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. African Armed Force 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: American 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic mental any injury or other traumatic mental and injury or other traumati College (1-4 or 5+) Elementary/Seconday (0-12) 10th Grade Laborer Construction Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bernard Parker Bertha Flowers DECEMBER 22, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrice White-Niece 2906 The Alameda Baltimore, MD 21218 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 12-29-10 4 Donation 5 Other (Specify) Metro Crematory Catonsville, 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition COLON CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Director for est a nonsechienne of Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery GREGORY GRAHAM 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Pregnant at time of death Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has funeral director, page 2 performed? Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 X No ျာ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 🗌 Yes Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖹 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December ²21,2010 00:30 Francis Donald Goodrich, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country Maryland 8. Date of Birth **Funeral** Months Days Hours Min Sept. Day Year) 1926 Director 84 213-28-2947 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Ocean Pines Worcester 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 1135 Ocean Parkway Unit 316 21811 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Ś 1 Never Married 2 X Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 7: nt of Health and Mental Hygiene. It if item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Clerk Western Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Francis Ellsworth Goodrich Olivia Gertrude Flannagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1135 Ocean Parkway Unit 316, Ocean Pines MD 21811 Mary Goodrich-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o 1 State 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Dec. 28, 2010 Baltimore Maryland 4 / Dona . Si 22. Name and Address of Facility Amorose Funeral Home Inc. 1328 Sulphur Spring Road, Arbutus Maryland 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Esophageal (Due to (dr as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) if any, leading to immediate sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: ပ္ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide 1 Tyes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State) To the Hospital within 24 hours a To the Funeral C 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. o completed cause of death (Item 23a) (Type, Print) Atlantic General Hospital, 9733 Healthnay Dive, Berlin, MD 21811 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 40807 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $^{\text{Marth}}_{12/23/2010}$ 7:00 P M Richard Philip Gensel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

OU 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**▼** M 2 □ F Months Hours Min 2/11/1936 Director 262-46-9209 74 OH Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Carrol1 MD Woodbine ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral 5525 Woodbine Rd. 21797 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1X Yes 2 □ No ģ 1 Never Married 2 Married If Yes, Give Year or Dates. 1954–58 1 ☐ Yes 2X No Specify "natural". Specify: White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 John H. Harland Co. Printer Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F e 1 and 2 should be fill of Health and Mental If item 27 is marked ည Richard W. Gensel Jessica Aultchel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Mary Gensel/Wife 5525 Woodbine Rd., Woodbine, MD 21797 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State <u>→</u> cemetery, crematory or other place, ☐ Burial 2XXCremation 3 ☐ Removal from State 9 Department of Important: If any injury or Carroll Crematory 12/29/2010 4 Donation 5 Other (Specify) Winfield, MD Sig e of Funeral Service Licen Burrier de Green Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 3175/10-10 17/23/4 disea ondition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 page 2 should within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should

Be

Certificate:

Baltimore, Maryland 21215-0036

2 No Yes 2 WN 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 10 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury 28b . Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

X

Signature

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3115

Registrar

Westminste

10-09826							
Maurice Gordon							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Maurice Gordor	ו	amend #193	ate of Maryla		aftment of rtificate of		Mental Hy	_	eg. No.	U +U0U0
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-Qicai Exam	mei	1144	Maurice Lydell a. Facility Name (if not institution, give street and number)			Gord 4b. City, Town, or L		Decembe	r 20, 2010 4c. County of	
	5015 Schaub Avenue					Baltimore				
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Bir		9. Birthplace (State or oreign
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Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and I Important: If item 27 is in nijury or other traumatic		1 X Burial 2 Cremation	3 Removal fro	m State	crematory or oth	ner place)				•
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Dem Dem		Hum	Bothe	Ke,	Ma:	ame and Address on F/H	West	Balt	imore, N	4d 21215
Physician /Medical		23 Part I. En e the disease, or failure. List only one cause	complications that cal on each line.	used the death.	. Do not enter th	ne mode of dying, si	uch as cardiac or	respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
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Division of Vital Records, rate or Attending Physician: The law requires after death. al Director: After this certificate has been seen ited in by the fineral director, page 2 should.	Completed							24a. Was a autop		re autopsy findings available r to completion of cause of
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	(Check only Certifying Pr	nysician: To the best niner: On the basis of							
To with Com	Mec	29b. Signature and title of certifie	and manner sta	ted.		29c. License r	number		29d. Date signed	(Month, Day, Year)
		Calesi	16	X/1	110	O.C.M.	.E.		December 21	, 2010
OK June,	ŀ	30. Name and address of person		,	,			0.4		
1 1	250		Assistant Medica	12.	-mile-	n Street, Baltim	ore, MD 212	U1		
Si Regis	ate trar	31. Date filed (Month, Day, Year)	10 Geneur	J. J.	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER Day 20 Physician/ 2010 2:55a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL TOWSON CENTE BALTIMORE 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth Social Security Number 6. Sex Funeral Days Hours 1 M 2 X Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b, County City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Funeral Director 1 Ses 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S Armed Forces? Race - American Indian. Black, White, etc. , or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo 21215-0036 If Yes, Give Year or Dates 1 Tes 2 Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Manone. College (1-4 or 5+) Be other's Name (First, Middle, Maiden Surname) 17. Father's Baltimore, Marylańd မ Informant's Name/Relationship (Type, 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Baltimore, 1 9-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Service Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final Metactatic Physician INCHOUN disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death ☐ Ectopic pregna
☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tailure 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No **Director:** After this certificd in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21 2010 DO056156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles Street Baltimore. w 31. Date filed (Month; Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7-23 nnie Medical 4a. Facility Name (if not institution, give City, Town, or Location of Death 4c. County of Death **Examiner** timore Thwi 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** 2 Months Hours Min. 0 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland must be notified at Director imor 1 Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? JorthwickRoad Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian injury or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ō þ filed within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 📉 o Specify: 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education Decedent's Usual Occupation 16h, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working t of Health and Mental Hygiene. If item 27 is marked other than fp. DO NOT use retired) Saconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. မ 19b. Mailing Address (Street and Number or Rural Route Number 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State 1 Marial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify) noval from State 21. Signature of Funeral Service Licensee 01 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital 2 No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 2 Accident 3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 2010 sp of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. Albert S. Gump 20 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore Future Care North Point Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours (Month, Day, Year) 215-14-9092 **Director** 88 ulv9. 1922 MDUsual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5109 Green Hill Avenue 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc. þ 1 X Never Married 2 Married Yes 25E No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Security Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard 3rd Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maud Luizey Benedick Gump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Schuler 1045 Chester Road Middle River MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Most Holy Redeemer 12/23/10 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility c. Name and Address of Facility 300 Connelly Funeral Mace 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Opset and Death Physician, n 2ar disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>호</u> 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed Yes 2 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🔲 Yes 2 4 မြ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Man of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **√**Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signature

8 2010

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		Please Type or Print in Black In State of Maryland / Dep	ndelible Ink. Ensure All Co eartment of Health and Menta	•	egible.
	_	, FOI	ertificate of Death	Reg. No.	010 40812
Physicia /Medic		1. Decedent's Name (First, Middle, Last) RALPH WILLIAM GUY	Ma	te of Death onth Day CEMBER 2	3. Time of Death 4,2010 6:10 p ^M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		ounty of Death
Funeral		GENESIS HERITAGE NURSING CTR. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	BALTIMORE of If Under 1 Year If Under 24 Hrs. 8. Da		BALTIMORE 9. Birthplace (State or Foreign
Director		212-42-2497	Months Days Hours Min. 12/	te of Birth onth, Day, Year) 30/1943	MARYLAND
hours after death with the Maryland hours after death with the Maryland tural", or items 23a or 28a-f show at Evantage 20	_	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 XYes 2 ☐ No
ours after death with the Marylan ral" or items 23a or 28a-f show	Director	MD N/A BALT 10e. Street and Number ***	IMORE 10f. Zip Code	10g Citize	en of What Country?
3a or		104 S. WOLFE STREET	21231		U.S.A.
death	Funeral		. Was Decedent of Hispanic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican,	es or No-	. Race - American Indian, Black, White, etc.
s after	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo	1 ☐ Yes 2 ☑ No Specify:		Inacific
72 hours "natural"	ed b	3 ☐ Widowed Divorced Year or Dates:	edent's Usual Occupation	16b. Kind	WHITE I of Business/Industry
	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)		
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t be fill that H he of the other control of the other control of the other control of the other control of the other control of the other of the oth	Be o	17. Father's Name (First, Middle, Last) RALPH WILLIS GUY	18. Mother's Name (First)	, Middle, Malden Si BLANCH	•
should nd Me mark matic	ည		ling Address (Street and Number or Rural Rout		
permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, II.			8 NORTH POINT RD.,		
es 1 a of He of He item		20a. Method of Disposition 1 ◯ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposerery, creation, and the state of the s	position (Name of particular place)	20c. Loca	ation - City or Town, State
tment tant: land		4 Donation 5 Other (Specify) OAK LA	WN CEMETERY 12/29/	10 BALT	IMORE, MARYLAND
permi Depar Impor any ir		21. Signature of Funeral Service Licensee	22 Name and Address of Facility 2 ZEILER INC	FUNER	AL HOME
-		23a. Part 1. Enter the disease, or complications that caused the death. Do not el	1901 EASTERN AVENU		Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	SKINIS 14M	PHOM	1 A Interval Between Onset and Death
/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):		7 (1 -	
Examiner	L	Se wentially list conditions b.			
ted nsit	Examine	Se, uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
be executed iician and burial-transit	Exar	that initiated events c			
bur be	ā	d			
The law requires that the death certificate ate has been signed by the attending physi page 2 should be detached for use as the b	Physician/Medic	IF FEMALE:			
ath co	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy	23	d. Date of delivery Month Day Year
the de	ysic	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		
e law requires that the di has been signed by the e 2 should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	3e. Did tobacco us	e contribute to the cause of death?
equire en sig	ed b	CORONARY TRIERY DIS	EME.	1 ☐ Yes 2 ☐	No 3 Probably 4 ☐ Unknown
law ri as be	Completed		24	4a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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endin sath. or: Aff	atio	1 → latural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No		
or Att fter de Direct in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		cation (Street and ity or Town, State)	Number or Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I	S	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and de	ie to the cause(s) s	and manner as stated
e Hos n 24 h e Fun	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or one) and manner stated.	investigation, in my opinion, death occurred at t	the time, date and p	place, and due to the cause(s)
Vithir Comp	Me	29b. Signature and little of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
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41		30. name and address of person who completed sause of dealer (tem 234) Type	Perint) SY10-ARIT	CHIE	HLGHWAY,
Sta	te	31. Date filed (Month, Day, Year) 32. Aegistrar's Signatur	10 - 4 - WAD - 5	1225)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December ľ9, 20T0 Christine Lynne Guthrie 5:52 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4 Monroe Place Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, **Funeral** 217-11-5169 1 - M 2 X F Hours Director 39 January 971 Usual Residence of Decedent or 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland items 23a or 28a-f shorer must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland| Montgomery Rockville 10e Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 4 Monroe Place 20850 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Specify: White Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Public Health Analyst Federal Government event, 1 Be permit. Page 1 and 2 should be filed. Department of Health and Mental H-mportant: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Taylor Guthrie Janet Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Etter / Spouse 6113 Calico Pool Lane Burke, Virginia 22015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State December Montgomery Crematorium 4 Donation 5 Other (Specify) Bethesda, Maryland 22, 2010 21. Signature unefal Service 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. MO1607 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 2216 Medical resulting in death) Due to (or 15 a cons, quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) -transit the Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 wonths? Pregnant at time of death Month Day Year the 9 Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

Yes 2 \(\square\) No Hospital Hot မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1
Natural 5 Pending Self work? 1 ☐ Yes 2 🔀 No Accident Investigation 19 2010 filled in by the f 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Ro City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) Roch base> 24 hours 208 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 Signature and title of cent 29c. License number 29d. Date signed (Month, Dav. Year)

DHMH 17 Rev 7/2009

State

Registrar

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31. Date filed (Month, Day, Year)

Ira N. Brecher, M.D.

28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

er mo omE

Registrar's Signature

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524 Hawkesbury Lane, Silver Spring, Maryland 20904

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over R. Gray		State of Maryland / Department of Health a			2010 2010	LARIL
		1- For State Certificate of Death		-	g. No.	, , , , , ,
Physici ledical Exam		Decedent's Name (First, Middle,Last)		Date of Death Month December		3. Time of Death 1255 hrs
euicai Exaiii	mer	Glover R. Gray	or Location of Death		2, 2010 4c. County of Dear	
		Sinai Hospital Baltimore			io. Godiny of Bog	
Funeral		5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes		_		rthplace (State or Foreig
Director		1 M 2 F 82 Yrs. Months De	ays Hours Min.			ountry) Outh Carolin
8		Usual Residence of Decedent				
ow any		10a. State 10b. County 10c, City, Town or Location				10d. Inside City Limits 1 Ves 2 No
Aaryland 28a-f show 1 at once.	cto	MD Baltimore 10e. Street and Number 10f. Zip Code		10	g. Citizen of What Co	Λ
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she at Examiner must be notified at once	Director		21207		USA	
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s after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X N			Specify: b1	
hours "natu		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16b. Kind of Business	/Industry
-0036 ed within 72 ygiene. other than "	Completed	none none disabled			none	
215-0036 be filed within 72 hou nital Hygiene. rked other than "nai	Con	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, M		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	George Gray		le Gray		
D 2. should and M.	ပို	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street, 19b. Address)				
more, MD 2's and 2 should set of Health and Mnt: If item 27 is unrother traumatic		Sarah Hall/niece 4001 Dorche 20a. Method of Disposition 20b. Place of Disposition (Name of c		Date Date	Ore, MD 2 20c. Location - City o	1207 r Town, State
Baltimore, permit. Pages I ar Department of Her Important: If ite	M	1 Burial 2 Cremation 3 Removal from State crematory or other place)				
Baltimo permit. Page Department o Important: injury or oth		4 Donation 5 Notice Specify in state 21. Signature of Funeral Service Licenses 1. On 1 d S 22. Name and Address State Ana	ss of Facility	1 (55 57	. Baltimor	
Dep Der	8	ennilos State Ana	-		. Baltimor	e Street
Physician		23a. Rart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line.	g, such as cardiac or		st, shock, or heart	Approximate Interval Between Onset and
Examiner	Ė	Immediate Cause (Final disease or condition resulting in death)				Death
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Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medical	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnar	ncy	Month	Day Year
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Vital Records, P.O. B hysician: The law requires that the d this certificate has been signed by the I director, page 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		acco use contribute to 2 ✓ No 3 Pro	
LS, F quires en sign				24a. Was ar		bably 4 Unknown utopsy findings available
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n of V ing Phy After thi funeral d	<u>-</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. I	jury at Work?	28d. Describe ho	ow injury occurred	
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Divisital or At urs after du lied in by	iffice	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	building, etc.	28f. Location (St or Town, Sta		ural Route Number, City
Divisior To the Hospital or Atteod within 24 hours after death To the Funeral Director:	Cen	4 Homicide determined (Specify) Single Family Home	110	001 Dorcheste	er Road, Baltimore,	MD
To the Hos within 24 h To the Fun completely		29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, cone) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion				
Tot with Tot	Medical	and manner stated.	nse number		29d. Date signed (Mo	
•			.M.E.		December 3, 20	
		In address of person who completed cause of death (Item 23a)				-
	2. 2	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Balti	imore, MD 2120	01		
9	ata	31. Date filed (Month, Day, Year) 2. Registrar's Signature				

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DHMH 17 Rev 1/2001 OCME 2006

Registrar

			1- State of Maryland 7 Dep	artment of Health and M <i>rtificate of Death</i>	ental Hygie	2010	40815
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		O1 II Cohn In		Month December	17, 2010	12:20 PM
	/Medio Examin		Carl W. Gohr Jr 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	BOOME	4c. County of Death	1
1	ZXXIIII		Hill Haven Nursing & Rehab	Adelphi		Prince Ge	orge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		place (State or Foreign
٨.	Director		577-36-9778 1₩ 2□F 82 Yrs.	Months Days Hours Min.	Nov 12,	ear) Cour 1928 Mic	higan
	P .		Usual Residence of Decedent		No v 12,		
	ırylar show	_	10a. State 10b. County 10c. City, Town or Le	cation		1	10d. Inside City Limits
	e Ma	cto	MD Prince George's Berywn	Heights			1 ☐ Yes 2√ No
	ith th or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	ntry?
	23a	a	5712 Ruatan Street	20740		USA	
	se se se se se se se se se se se se se s	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or li	by Fu	1 ☐ Never Married 1 ☐ Yes 2▼ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at	d b	Salvidowed 4 Divolced Year or Dates:				
쟌	"nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work.	ing 16	b. Kind of Business/In	dustry
12	withir	m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		education	
2	filed Hygid ther int.	Ö	17. Father's Name (First, Middle, Last)	teacher	e (First, Middle, Ma		
an	od o	Be	Carl William Gohr Sr			edericka S	Schultz
\geq	houle d Me mark matk	L C		ng Address (Street and Number or Rura			
Maryland	d 2 s th an 17 is trau						(0006)
Ġ	1 an Heal em 2		20a. Method of Disposition 20b. Place of Dispo	Cailen Court Belt		MD 20740 c. Location - City or To	own. State
Baltimore,	ages nt of t: # h		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		,	,
₫	it. Purtue		'4 ☑ Donation 5 ☐ Other (Specify)	2. Nome and Address of Equility			_
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment must be notified at once.			tate and action you are		Baltimore S	itreet
			23a. Pat1. Enter the disease, or complications that caused the death. Do not en	altimore, MD 2120			Approximate
			shock, or heart failure. List only one cause on each line.	- 1 - 1	or roopii atory arroot	*	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	ry Arrest			
#	Examiner		Due to (or as a consequence of):	dial Talan	4		
		e e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence ot):	rdial Infanc Cardiovascule	<i>SF</i>		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	Cardiavassule	2 DIEM	2500	
,	al-tra	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):		7 2340	130	
8760,	icate be executed physician and the burial-transit	dical	La Diasatos 1	40llitus			
.89	ificati g phy as the	edic	U,				
Вох	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
ă	death a atte d for	icia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5[□Ectopic pregnancy □ Other (specify)		Month	Day Year
o.	that the death cer ed by the attendir detached for use	hys	9 □ Unknown				
٣.	The law requires that the tee has been signed by thoage 2 should be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
ğ	quire an sig uld b		Congestine Heart Failure		1 ☐ Yes	2 1 No 3 Prob	pably 4 □Unknown
Records,	s been si	Completed	_ Chnonic Runal Failure S.	teyo 4	24a. Was an	24b. Were auto	ppsy findings available
æ	The la	E O	Bladder Carcinoma.	7	autopsy performed	d? death?	mpletion of cause of
ita		0	25. Was case referred to medical	26. Place of Deati	1 Yes 2 1	No 1 ☐ Yes	21110
\geq	Physician: The lav this certificate has ral director, page 2 a	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Other		e 6 ∏Other (Specif	€)
Division of V			27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		,
0		atio	1 ☑ Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No			
N N	of or Attend after death Diractor:	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, tarm, stream building, etc. (Specify)	eet, factory, office	28t. Location (Stree City or Town, S	et and Number or Rure	al Route Number,
	tal or	Certification;	building, etc. (opecny)		ony or rown, c	Jiaio)	
	To the Hospital or Atten within 24 hours after deat To the Funaral Diractor: completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	n occurred at the time, date and place,	and due to the caus	se(s) and manner as s	tated.
	the H iin 24 the F iplete	ledicai	one) and manner stated.	vestigation, in my opinion, death occurr	eu at the time, date	and place, and due to	ome cause(s)
	To To Com	Σ	29b. Signature and title of certifier	29c. License number		. Date signed (Month,	
			1915	47867		12/17/20	10
			30 Name in the reson who completed cause of death (Item 23a) (Type,	Print)	\u00e4		
			30 Name of John Strain	KKI #Z16, FOCKI	MIC, MI	> 20852	
	Sta		31. Day Eng (Mant & Day) Vary) Senem S. Garles				
	Registr	ell. .∌	Maria Salar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryla	•	rtment of H tificate of D			ene 3. No. 2 0 1 0	40816
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	coss				2. Date of Death December	27 2010	3. Time of Death 3:00 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat						4c. County of Deat	h
256	Funeral		1704 Gardiner Road 5. Social Security Number 6. Sex	7. Age (In vo	s. last birthday)	Hunt Val	If Under 24 Hrs.	8. Date of Birth	Baltimo	thplace (State or Foreign
	Funeral Director		253–20–7177	M 2 X F 88		Months Days	Hours Min.	August 24	1922 Gec	rgia
	and show dat	ior	Usual Residence of Decedent 10a. State 10b. County		City, Town or Loc	ation				10d. Inside City Limits
	e Maryl r 28a-f notifie	Jirec	Maryland Baltimor	e T	owson	10f. Zip Code		1.00	g. Citizen of What Co	1 Yes 2 X No
	with the 23a oust be	Funeral Director	1 Southerly Court				1286	10	U.S.A.	
920	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	lf.	/as Decedent of His Yes, specify Cubar ☐ Yes 2 🛣 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	72 hour n "natu Aedical	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give ki	ent's Usual Occupa ind of work done do NOT use retired)		ing	6b. Kind of Business	
212	I within ygiene.	Be Cor	Elementary/Seconday (0-12)	College (1-4 or 5+)		eeper			Jewelry Wh	olesale
land	be filec ental H ked ot ic even	To B	17. Father's Name (First, Middle, Last) Ernest Henry Roberts	18. Mother's Name Ethel M			_{e (First, Middle, Ma} 1ae Waters	,		
Aary	I and 2 should be file F Health and Mental H item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type,						ity or Town, State, Zi	
	1 and 2 f Health item 27 other t		Denise Stokes / Daug 20a. Method of Disposition	201	b. Place of Dispos	sition (Name of			Oc. Location - City or	
Baltimore,	, Page tment o tant; If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	irdensOfFa	atory or other place ith Ceneter	y 12-24	I	altimore,	
Ball	permit Depar Impor any in	Į į	21. Signature of Funeral Sanda Lice La	1		Name and Address 050 York Ro	s of Facility Ruc oad Tows	ck Towson son, Maryl	Funeral Ho and 21204	me,Inc.
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of	ations that caused the decause on each line.	eath. Do not enter	r the mode of dying	, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Hrysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	e paer e of):	ionce	1			gigears
	Examiner	e	Sequentially list conditions, b.	Due to (or as a cons	equence of):					
	uted nd ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	200 10 (0) 43 4 00113						
_	cate be executed physician and s the burial-transit	edical E)	resulting in death) Last	Due to (or as a cons	sequence of):					
8760	tificate I ng phys as the	Medi	IF FEMALE:							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pred 1 Live Birth 2 F 4 Pregnant at time 9 Unknown	у		23d. Date of de Month	llive ry Day Year		
ds, P.O.	requires that the der been signed by the s should be detached	þ	Part II. Other significant conditions control	ibuting to death but not	resulting in the ur	nderlying cause give	en in Part I.			o the cause of death?
Division of Vital Records,	: The law recate has be ; page 2 sho	Completed						24a. Was an autopsy perform	prior to death?	stopsy findings available completion of cause of
Vital	ysician s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	spital:	☐ ER/Outpatient	Othe	er: 4 Nursing H		ce 6 X Other (Spec	Daughters
on of	anding Physath. Pr. After thi	Certificate: 1	27. Manner of Death 17 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year,	28b. Time of	28c. Injury work	at	28d. Describe how		
ivisi	if or Attendi after death Director: A d in by the f		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		et, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Medical	29a. Certifier (Check conly one) 3 Certifying Physici Certifying Physici Certifying Nurse I	an: To the best of my kn : On the basis of examina Practioner: To the best o	ation and/or investi	igation, in my opinio	n, death occurred a	it the time, date and	place, and due to the	cause(s) and manner stated.
	To the vithin to the comple		29b. Signature and gittle of certifier	s, m	65	29c. License	8525	29	d. Date signed (Mont	h, Day, Year)
7			300 lame and address of person who com	ipleted cause of death (I	tem 23a) (Type, P	Plula	STRI	Dmi	MO	21204
H	Sta Registra		31. Date filed (Month, Day, Year) DEC 2 8 2010	32. Registrar's Si	nature	1	- "1 01	7	1	t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Mildred December 12:15 P ^M Marie Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 510 Southwell Road Linthicum 8. Date of Birth
Sep. 25, 1918 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthdav) 1 🗆 M 2 🗶 F Min Director 219-58-2627 92 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 Southwell Road 21090 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after white 1 ☐ Yes 2X No Specify: Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic or Henry C. Gable Annie B. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090 Elizabeth A. Plummer-daughter 531 Forest View Road, Linthicum Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🛣 Cremation 3 🗆 Removal from State 12-22-2010 Glen Burnie Maryland Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. . Signature of Funeral Service Licensee 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Due to (or as a conse **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a considuence of sician and burial-transit Exami Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be del 23e. Did tobacco use contribute to the cause of death? by or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 Yes 2 No 24 hours after death.
Funeral Director: After this certificeted filled in by the funeral director, 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completed file 29a. Certifier To the 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print)

3

DHMH 17 Rev 7/2009

State Registrar PAUL

22

PL. BAOTMONE, NO 71202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ December 23 4:58PM 2010 Gary Hayes Jr. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** X M 2 F Min. Ol Os Days Hours Year) Country) MD 32 Director 216-92-6999 Usual Residence of Decedent shov 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County ms 23a or 28a-f sho must be notified at Director 1 🌠 Yes 2 □ No NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4001 Belle Ave 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dez Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decements usual Occupation
(Give kind of work done during most of working life, DO NOT use retired)

Tamily Service

Coordinator Elementary/Seconday (0-12) College (1-4 or 5+) Win Family Service's <u>2th grade</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Gary Hayes Sr. Desiree Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 Belle Avenue, Baltimore, Maryland Angenette Hayes-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/31/10 Woodlawn Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) Marcha Afdr Hof West anature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line.

m. ediate Cause (Final Malintant Plana L. Cause)

Malintant Plana L. Cause

Tisease or condition Approximate
Interval Between
Onset and Death
MM Hes Maliehant Physiciani isease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** 0 Sto chondroma years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: မှ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No ✓ Natural 5 Pending n 24 hours after death. e Funeral Director: A bleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature RES - 000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 Sinai Hospital of Baltimore Adhanom eamrat

State

Registrar

31. Date filed (Month, Day, Year)

8

AYES

ARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December MAK 7:15Y 2010 Medical Examiner give street and number) 4b. City, Town, or Location of Death County of Death GHEN mne **b** If Under 1 Year Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months Year 052-24-7189 Director 80 Yrs Country) 04 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County Examiner must be notified at 10c City Town or Location Director 10d. Inside City Limits Anne Arundel Glen Burnie 1 ☐ Yes 2 🛣No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 211 Scott Ave 21060 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2X Married þ Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify. Black event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working marked other than Anne Arundel Baltimore, Maryland 2161 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha 12th grade 5yrs+ Professor Community College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joel P. Holman Sr. Elizabeth Ann Bishop other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Holman-Wife 20a. Method of Disposition Scott Ave, Glen Burnie, Md 21061 Important: If item any injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State ö 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) On-Site 12/27/2010Baltimore, Md . Signature of Funeral Service Licens 2. Name and Address of Eacility. March F/H West |4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-transit that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Year n signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ڍا 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy After this certificate I perform death? 1 Yes 2 Wo Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? Accident Investigation 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 3 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Physician/ S. Howard 2010 0:000 20 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Alice Manor Nursing Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Hours (Month, Day, Year) Country) 1 🗆 M 2 🔀 F 83 Director 242-42-5723 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State 10b County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at with the Maryland Director 1 X Yes 2 No Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 21213 U.S.A. 3415 Ramona Ave Page 1 and 2 should be filed within 72 hours after death vert of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Hospital Medical Technologist 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ျ Mamie Smith Stuart Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3415 Ramona Ave, Baltimore, Md 21213 Thea Brooks-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of I Important: If its any injury or of 1 Burial X Cremation 3 Removal from State 12/27/2010Baltimore, Md On-Site 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funeral Service Lie 22. Name and Address of Facility
March F/H West al Baltimore, 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final brogsessive Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Obo Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Live Birth 2 Live Birth 2 Pregnant at time of death Year Month in the past 12 months? Day 5 Other (specify) 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' 1 🗌 Yes 2 🗎 No Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be completed filled in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Tyes 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 4 Homicide Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

within 2

(Check

31. Date file

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HASHMI

8

EUMAN

821W.

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Finte 308, Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Moses Henry Jr. pecember 7010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a itimore Social Security Number 1 Year If Under 24 Hrs. Days Hours Min. 7. Age (In yrs. last birthday) 6. Date of Birth 9. Birthplace (State or Foreign Country) SC **Funeral** 1 ₹ M 2 □ F Months 1 9 1 9 1 9 Year) 61 Director 247-82-6169 Usual Residence of Decedent 10c. City, Town or Location 28a-f sho 10b. County 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 1 Yes 2 □ No n/a Mi Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 South Culver Street 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Specify.African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry permit. Page 1 and 2 should be filled within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Bons Secour Hospital Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moses Henry Sr. Lucille Iemon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy M. Cooper/Daughter 31 Brookebury Drive, Apt. 1A, Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Veterans 1/6/2011 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Whie Funeral Time P.A. of Ralto. Co. re of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1: Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) (0 Medical Due to (or as a consequence of): 152 Examiner Sequentially list conditions, if any, leading to minimum cause. Enter Underlying Cause (Disease or linjury Examine True to Lineau consequence offi-The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Certificate: To Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autons 1 Yes 2 No certificate 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Hospital or Attending Physician: filled in by the funeral director, 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 - Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation Director 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined To the Hospital of within 24 hours are To the Funeral D Medical 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) (eX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MM V 31. Date filed (Month L State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Hudson George Arthur 010 Medical 4a. Facility Name_fif notvinstitution, give street and number) **Examiner** 4b. City, Town, or Looation of Death Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days Hours Min. SEP 13 1918 Country)
Massachusetts Director 031-01-8107 92 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane, HR 335 21228 USA within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 WW II 1 Yes 2 No Specify Specify. Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Automotive Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Transmissions Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hudson Charles John Izette Alice Farnsworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madelon Moe Hudson, wife 719 Maiden Choice Ln., HR 335 Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Important: It any injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/28/10 Baltimore, MD Signature of Funeral Service Licensee George 22. Name and Address of Facility Cremation Society of MD, MacNabb Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 DNO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number OXI of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ John J. Holt Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Transitions Healthcare Sykesville Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth Funeral May 7, 1931 Months Min 224-36-3737 Director Usual Residence of Decedent 28a-f show 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4115 Hanwell Road 21133 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 V Yes 2 No 1952

If Yes, Give

Year or Dates. -1955 Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify Specify: Completed 3 Widowed 4 Divorced -195516a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MD Port Authority 4 Business Manager Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Luke Holt Susan Berkley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Holt 4115 Hanwell Road, Randallstown, MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc | 12/27/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ STAGE RENAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural injury 5 Pending work? Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined completed filled in Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

3. Time of Death

:08

9. Birthplace (State or Foreign Country) Virginia

Black

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dav

1 Yes 2 No

29d. Date signed (Month, Day, Year)

2010

DECEMBER 27

1 Yes 2 No

 $2\overset{\text{Year}}{0}\overset{\text{1}}{1}0$

Registrar DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

LEUNARD RICHARDSUN

M.D:

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

057722

M.D. 1838 GREENE TREE RUAD # 300 PIKETVILLE MI) 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 12:00 M Pearlean Hopkins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Kirkwood House If Under 1 Year If Under 24 Hrs **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Month, Day, Year) 30 1 □ M 2 💢 F Director N.C. 80 237-50-4185 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 USA 6401 Loch Raven Blvd 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2X XNo If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th grade College (1-4 or 5+) Food Services Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola Shearin <u>Johnnie Coppage</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 822 Reverdy Road Balto, MD 21212 Carolyn Lymon-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other pla Randallstown, King Memorial Pk 12/23/2010 MD 22. Name and Address of Facility March East F/II 21. Signature of Fun Service Licer 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Chronic Obstructive recise Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 7 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementi Yes 2 No 3 Probably 4 Unknown should b Completed Melli 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0015462 12/22/2010 me and address of person who completed cause of death (Item 23a) (Type, Print)

Miguel Karacuschansky 200 E, 33nd St #640

State Registrar

√ DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)
DEC 28 2010

32. Registrar Signat

BALTO, MD 21218

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 1tem 20b per fh. 26 per doc g910 12-28-10 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 ^{1. Decedent's Name (First, Middle, Last)} Richard Edward Harmon Sr 2. Date of Death 3. Time of Death Physician/ T2/15/2010 3:00amM Medical Examiner 4a. Facility Name (if not institution, give street and number)
1382 W Jarrettsville RD 4b. City, Town, or Location of Death 4c. County of Death Harford Forest Hill Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In yrs. last birthday) Funeral 213-28-9415 1 **X** M 2 □ F Hours 04/28/1931 79 Yrs. Director Usual Residence of Decedent 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Selbyville DE Sussex 1 Tes 2 XNo ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19975 23a Funeral 37190 Sugar Hill Way within 72 hours after death with USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: White Completed 3 Widowed 4 □ Divorced Year or Dates Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel traumatic event, the Weldor 10yrs Be 18. Mother's Name (First, Middle, Maiden Surname)
Edith Lynch 17. Father's Name (First, Middle, Last) ပ Henry Harmon permit. Page 1 and 2 should I Department of Health and Me Important: If Item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1382 W Jarrettsville Rd Forest Hill MD21050 Bruce C. Harmon Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 10 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial XXCremation 3 ☐ Removal from State 12/17/01 Glen Bernie MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem S ature of F eral Service Licen 22. Name and Address of FacilitySimplicity Crem & Fun Ser ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner culities Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No Division of Vital Records, P.O. ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 2 No certificate Yes 2 1 Tes tor: After this certific the funeral director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) son's Hospital Other: 1 🗌 Yes 2 No ျ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 24 hours after death.

Funeral Director: A 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Fractionar: T. The basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32277 Dacember 17,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 V CIEN. Magho 5.

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State Registrar 31. Date filed (Month Per Year) 8

2010

32. gist v's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day. Hanlin Rebecca Rosemary December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Baltimore Washington Medical Ctr. Anne Arundel Social Security Number 9. Birthplace (State or Foreign Country)
South Carolina 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Feb. 9 1952 1 🗆 M 2X F Days Hours Min 219-60-5065 58 Director Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City. Town or Location with the Maryland notified at 10d. Inside City Limits Director Baltimore 1 Ves 2 No Dundalk 10e. Street and Number 10g. Citizen of What Country? 0 10f. Zip Code the Medical Examiner must be Funeral items 23a 21222 United States 2818 Plainfield Road death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. jo, 1 XNever Married 2 Married Yes 2 X No þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the In Public Schools Cafeteria Worker 12 Years Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mildred M. Widener James T. Hanlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 550 M. Richie Hwy. Suite 145 Severna Park, MD Robert S. Jacobs (Personal Reg) 21146 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/27/2010 4 Donation 5 Other (Specify) Elk Garden, WV Kaubaugh Cemetery Duda-Ruck Funeral Home of Dundalk, Inc. . Signature of Funeral Service Ligenses Þ Maryland 7922 Wise Ave. Dundalk. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Canres disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) To the Funeral Director: After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Vatural injury 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40827 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 22, 2010 Ethel Heselden 3:20 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blakehurst Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🙀 F Months Days Hours Min. Jan 13, New York 067-18-7465 89 Yrs. **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director MD 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 1055 W. Joppa Road, Room 111 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental his marked o မှ Bruce Harold Quackenbush Anna other traumatic Augusta Schwanitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Nancy Norton-daughter 13306 Beaver Dam Rd., Hunt Valley, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv Corp 12/23/10 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William G. Dau Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 4 Weeks Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 conths?
1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director; After this certificate has been sis completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending iniury work? 1 ☐ Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

December 22 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARVES W) 6701 Charles ST toisson MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year IWaszko Sterhan 1:15 A M December 20,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Contreville Comet DRIVE 255 If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F 01/05/1925 215-32-2716 85 UKRAINE Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10g. Citizen of What Country? 216 BALTIMORE ROAD 21666 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC DOMINO SUGAR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 UNKNOWN IWASZKO UNKNOWN 19a. Informant's Name/Relationship (Type. Print)

DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH IWASZKO/ IN-LAW 216 BALTIMORE ROAD, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12722/10 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MICHAEL"S UKRAINIAN 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Funcial Service Licensee 22 Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lancer Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed?
Yes 2 710 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) | HOS Cice 1 | Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Gluste 2 D 66371 December 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Fype, Print) wans Lave, Easton, Mary land

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State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 1 tems 20a-c per fh g910 12-28-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 125P Physician/ Month OBI 2 2010 Medical Facility Name (if not institution, give street and number) 4b. City **Examiner** n, or Location of Death 4c. County of Death Age (In yr). last birthday If Under 9. Birthplace (State or Foreign Country)
Maryland Funeral If Under 24 Hrs. 8. Date of Birth 1 □ M 2 📭 Months Days Min. Hours 07/01/ 220-20-9129 Yrs. **Director** 82 ″1°928 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral Smallwood St Apt146 21223 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) mentary/Seconday (0-12) College (1-4 or 5+) 8th Grade Housekeeper <u>Private Homes</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unk Mary Buttercup Jubilee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Goode(sister) 1933 W. Saratoga St., Baltimore, MD 21223 20c. Location - City or Town, State Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 12-2^{Date}10 1 X Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee ²² Nansack dresho Face Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ rdwgenic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live leta usu.

Pregnant at time of death in the past 12 months?

1 Yes 2 2 Month Day Unknown 9 Unknown Part II. Other significant conditions ontributing to death but not resulting in the underlying cause given 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Fobably 4 ☐ Unknown 1 Tyes Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy death? 1 Yes 2 No 1 ☐ Yes 2 Z 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 4 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accider
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License numb 2010 30. Name and address of .Neal State Registrar

10-09748 Ernístine Johnso Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia। ेव। Examin	"	4.5	mary	ETHESTI	me Juli	Johnso	n	. .	Month December	r 17, 201	Year 0	2245 hrs	
AI LAGIIIII		Mary a. Facility Name (if not institution	n, give street and nui	mber)	4	b. City, Town, or L					unty of Deatl	1	
		1550 Moreland Avenu				Baltimore							
Funeral		Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under		B. Date of Bir	th(MM/DD/	YYYY) 9. Bir Forei	thplace (State or	
Director			1 M 2 XF	87	Yrs.	Months Days	Hours	Min.	07 2	4 2	0.	ountry) MD	
	-	18-18-8435 Usual Residence of Decedent	I M Z AF	01									
any		10a. State 10b. County		10c. City,	Town or Locati	on						10d. Inside City	
		MD NA		l E	Baltim	ore						1 X Yes 2	No
Maryland 28a-f show d at once.	핡	10e. Street and Number				10f. Zip Code			11	l0g. Citizen	of What Cou	intry?	
Mary r 28a ed at	Director		7 7 7			212	16				U.S.A		
 MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death and Mental Hygiene. tent 27 is marked other than "natural", or items 33a or 28a-f above at 75 is marked other than "natural", or items 33a or 28a-f above traumatic event, the Medical Examiner must be notified at once. 		1550 Morela		and Ever in 11	C 13 Wa	s Decedent of Hist	oanic Origi	n? (Spec	ify Yes or No	o- 14.	Race - Ame	ncan Indian, Black	к,
h with	Funeral	11. Marital Status 1 Never Married 2 M	1	edent Ever in U. orces?	S. If Y	es, specify Cuban,	Mexican,	Puerto Ri	can, etc.)		White, etc.		
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id 2 shoulth and m 27 is aumati	Į	<u>Leon Johnson</u>	J <u>r-</u> Son	Lanh	7810	Clark Sition (Name of cer	netery.	<u>-ت ر</u>	Date	20c. Loc	cation - City	or Town, State	
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	-4	23a. Fart I. Enter the libease, of	or complications that	used the death	. Do not enter	the mode of dying,	such as c	ardiac or r	espiratory a	rrest, shock	, or heart	Approximate Between On	III.COI V
hysician Medical		failure. List only one caus	e on each line.	erotic Cardiov								Death	n
xaminer		Immediate Cause (Final diseas or condition resulting in death)		a consequence of		sease							
1		or condition resulting in death)	Due to (or as	a consequence o	JI).								
	_	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):								
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Box 68760, e death certificate b the attending physic ed for use as the bu	Physician/Me	23b. Was decedent pregnant in past 12 months?				etal death 3	Ectopi	c pregnan	ісу	N	Month	Day Y	'ear
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III. T	0	25. Was case referred to med				26.Plac	Other			7	م آهام	than Corns	
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Division of Vital Records, P.O. Box 6876U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	<u>٩</u>	27 Manner of Death	28a. Da	te of Injury	28b. Time o		ury at Wor		28d. Descril	oe how inju	ry occurred		
ding h. Aff	Certification:	1 ✓ Natural 5 P	ending (Mo	nth, Day,Year)		1	Yes 2	No					
IVISION or Attend after death. Director:	Sat	2 Accident In	vestigation 28e Pl	ace of Injury - At	home, farm, st	reet, factory, office	building,	etc.			nd Number of	Rural Route Num	ber, C
after Direct	1	3 Suicide 6 C	ould not be 200: in the control of						or Town	n, State)			
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	1 K		Physician: To the base	pest of my knowle	eage, death oc and/or investi	curred at the time, gation, in my opinio	on, death o	occurred a	t the time, d	ate and place	ce, and due t	o the cause(s)	
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H 3 H 3	ž	29b. Signature and title of cer	tifier					OGME		I -	ember 20		
7		111	11 ~	Ita.		0.0	C.M.E.			Dec	-111061 20	, 2010	
1.		Name and address of per	son who completed	ause of death (Ite	em 23a)								
6 m . I	8.7					111 Penn 9	Street P	altimor	MD 21	201			
DV	1	Theodore M King	Jr., MD. Assi:	stant Medica	i Examiner	TITEIIII	oticet, D	aitiiiioii	C, 1910 2 1				
νC	Stat	Theodore M. King, 31. Date filed (Month, Day, Ye		stant Medica Registrar's Sigg				altimon	5, 1410 2 1.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G910 12/29/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 12-53 PM Jones 21 2010 ecember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Hosbir al Baltimore Ballinore Cit 01 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 MM 2 □ F Months Days Min. (Month, Day, Yea Hours 85 NC Director 1925 228-34-5674 -18show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 U.S.A. 25 North Ellamont Street 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc þ 1 X Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Moving Company Truck Driver 5th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Edmonds Willie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, md 21229 North Ellamont Street, Linda Turner-Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/05/2011 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet `1/5/201 Owings Mills, Md 22. Name and Address of Facility March F/H West 4300 Wabash Ave, ignative of Funeral Service Licensee 21215 Baltimore, a. Papt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final Onset and Death lla Physician Atrial disease or condition has Medical resulting in death) Due to (or as a consequence of) Examiner gangrene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) nding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 Yes 2 L 9 Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Rena Disease 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, pag 2 🗹 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 M No Other: 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending 1 Tyes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining Physician: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21 2010 December M. D (RESIDENT RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Baltimore SANJAY Sinai MUNIREDO 31. Date filed (Month, Day/Year) 32. Registrar's Signature State 2 2010 Registrar

10-09356

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Ray Ar	nthon	y Jack	son
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		- For State Registrar		Ce	ertificate o	Deat	h				Reg. N	lo.		
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Aedical Examin	er	RAY	ANTHONY		JACKSON	Ī				Decemb	er 6,	2010		0020 hrs
		4a. Facility Name (if not instituti	on, give street and n			4b. City, T		ocation of	Death			4c. County of		
		Baltimore Washingto	n Medical Cent	er		Glen	Burnie					Anne Aru		
Funeral	7	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		er 1 Year	If Under	_	8. Date of E	irth (M	M/DD/YYYY)	9. Birth	nplace (State or Foreign ntry)
Director	- 1	084-46-4005	1XM 2F	55	Yrs	Month	s Days	Hours	Min.	SEPT.	8	1955	NE	w''YORK
	H	Usual Residence of Decedent												
any	-	10a. State 10b. County		10c. Cit	y, Town or Locat	ion								10d. Inside City Limits
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Maryland 28a-f show 1 at once.	ᇍ	10e. Street and Number	ARCIDLE		O LL LI DOIL	10f. Zip	Code				10g. C	Citizen of Wh	at Coun	try?
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2121 Muld be fil Mental I marked	o Be	UNKNOWN 19a. Informant's Name/Relation	shin (Type Print)		19b Mailin	a Address	Street		OTHY ber or Ru			, City or Towr		Zip Code)
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Baltimore, permit. Pages la Department of He Important: If ite	Γ	21. Signature of Funeral Service	e Licensee											HOME, INC.
10 8 2 4 4	66	Muane Z	Callo	wa		474 I	LANDO	VER	ROAD	HYAT	rsv:	ILLE,M	ARYI	AND 20785 Approximate Interval
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Box 68760, death certificate b he attending physic d for use as the bun		23b. Was decedent pregnant in		birth		etal death	3	Ectopic	pregnan	су	- 1	Month		ay Year
Sox 687 leath certifi e attending for use as 1	흥	past 12 months?	4 Pre	gnant at time of	doath	ther (Spe	cify)				- i			
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Division pital or Attendia ours after death. eral Director: Affilled in by the fu	ij		uld not be		home, farm, stre	et, ractory	у, опісе ві	Jilaing, et	· 1	or Towr			oi Nu	rat Route Humber, Oity
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Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certification the Funeral Director: After this certificate has been signed by the attending inpletely filled in by the funeral director, page 2 should be detached for use as	평	(onedit only	Physician: To the b	est of my knowle	edge, death occu	rred at the	e time, da	te and pla	ice, and o	due to the ca the time da	iuse(s) te and) and manner I place, and d	as state	ed. e cause(s)
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical		and manner		androi investiga				our ou at	anie, de				
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_	ł	30. Name and address of person	on who completed ca	use of death (Ite							•			
1		Ana Rubio MD. As	ssistant Medica	l Examiner	111 Penn	Street,	Baltimo	re, MD	21201					
St	ate	31. Date filed (Month, Day, Year	2010 82	Registrar's Sign	ature park	11								
Regist		ロEL ソガ	ZUIU 1/2	was fo	1 SAME CANAL	-								

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Issac Bennett Joyner State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day December 23, 2010 **Medical Examiner** 2020 hrs enne 55 ac 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital STU Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Hours 2 F Country) Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits D 1 Yes 2 No or 28a-f show , or items 23a or 28a-f shorr must be notified at once. more Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11 Marital Status 12. Was Decedent Ever in U.S 14, Race - American Indian, Black Armed Forces? 1 Never Married 2 Married Yes 2 No If Yes, Give Year No specify **全** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 18.Mother's Name (First, Middle, Margen, Surname 17. Eather's Name (First, Middle, Last) 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, ftate, Zip Code) Mosher henia 0 1+more 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 2 Cremation 3 1 V Burial Removal from State Memoria 12-30-2010 Other Specify Signature of Funeral Service Lice, 21229 National 23a. Part I. Enter the disease, or complication failure. List only one cause on each line. hter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease <u>ixaminer</u> or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical by the attending physician a ached for use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed ector, page 2 should be deta 至 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No death? 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Dec 23, 2010 Subject shot 1 Natural Division 1936 hrs death. 1 Yes 2 ✔ No Director: d in by the f Pending 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) 1000 Ashburton Street, Baltimore, MD (Specify) Sidewalk determined Funeral 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 24, 2010 30. Name and address of person who completed cause of death (Item 23a) OCME Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature State Registrar

			Plea amend	se Type or Pri Per ANA BD State of Ma	n t in E	Black Ir	ndelible In	k. Ensure	All Copies	Are Leg	jible.	
		•	For State Registrar	State of Ma	Certificate of Death					Reg. No.	10	40834
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	Examin		4a. Facility Name (if not institution, SUADY GREVE AD	-	DSPIT	AL		r Location of Deat	h	4c. County	of Death	nery
	Funeral Director			6. Sex 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h (Year) 930	g. Birthr Cour North	place (State or Foreign try) Carolina
		ř	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation		10.0000	,		0d. Inside City Limits
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	vith the 23a or st be n	eral D	10e. Street and Number 18889 Waring S	tation Road	#301		10f. Zip Code	20874		10g. Citizen of	What Cour USA	
920	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene. If it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces?	ver in U.S.			lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Blac	ce - Americ ck, White,	an Indian, etc.
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212	within ygiene.	Be Cor	Elementary/Seconday (0-12)	College (1-4 or 5	+)		ıck drive	er		trans		ation
Maryland	l be filed fental H rked ot tic ever	To B	17. Father's Name (First, Middle, La John Tennyson						me (First, Middle, [itche11	Maiden Surnam	e)	
Mary	Should hand hand hand hand to ma		19a. Informant's Name/Relationshi				-	and Number or Ru				Code) n, MD 20874
re, I	of Healt of Healt fitem 2		Yvonne Simon/d		20b. Pla	ace of Dispo	sition (Name of	- 1	Date Date	20c. Location		
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		1									
Ba	Depa Impo any i	S 9	21. Sign itu Funeral S. Vice Li	1 KKK	ctor		***	tomy Boa MD 21			more	Street
C	hysician Medical		23a. Pard 1. Enter the disease, or of shock or heart failure. List or immediate Cause (Final disease or condition resulting in death)	nly one cause on each line Card Due to (or as a	ic pu	lmon	ary ar		or respiratory arr	est,		Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions,	b. athe			515					
09289	cate be executed physician and s the burial-transit	edical Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c	a conseque	ence of):						
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🔲 Fetal	death 3 [Ectopic pregnand Other (specify)	су		- 1	ate of delive	ery Day Year
s, P.O.	res that the signed by a pe deta		Part II. Other significant condition oeripheral ar-			_	inderlying cause gi etes më					ne cause of death?
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Vita	hysicie his cert al direct	ပ	examiner? 1 Yes 2 No			_	nt 3 🗆 DOA Oth	4 ☐ Nursing I	Home 5 Resid)
ou of	nding F ath. r: After t e funer?	icate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig		(, Year)	28b. Time of injury	worl		28d. Describe h	ow injury occurr	red	
Division of Vital	al or Atte s after des al Directo ed in by th	Certificate:	3 Suicide 6 Could n 4 Homicide determi		ry - At hor c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rurai	Route Number,
_	re Hospit n 24 hour le Funera bleted fille	Medical	(Check 2 Medical Ex	Physician: To the best of xaminer: On the basis of ex Nurse Practioner: To the	xamination	and/or invest	tigation, in my opini	on, death occurred	at the time, date a	nd place, and du	e to the ca	use(s) and manner stated.
	To the Complete of the Complete of the Complete of the Complete of the other of the		29b. Signature and title of certifier	I ma	7	0.	29c. Licens	e number		29d. Date signe		
			30. Name and address of person w		eath (Item	23a) (Type, F	Print) Conter	Drive,	Rockvill			1 20850
ľ	Sta Registra		31. Date filed (Houth, Day Year)	32 Registra	er's Signatu	bark		· · · · · · · · · · · · · · · · · · ·				

1400

DECEMBER 8, 2010

TENNYSON JOHNSTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCI Dece 46 - 34,2010 Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, Examiner Baltimore 3514. MOTE KieL 8. Date of Birth (Month, Pay, May 29, 9. Birthplace (State or Foreign . Age (In yrs. last birthday, 62 Yrs. If Under 1 Year If Under 24 Hrs. Social Security Number Funeral Country)
Maryland 212-48-3829 Director Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 10a. State 1 Yes X No Arbutus Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227 5532 Oakland Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Be Completed by 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Healthcare** Customer Service Rep. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ျ Anna B. Regan John F. Kramer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5532 Oakland Rd., Arbutus, MD 21227 Catherine E. Kramer - Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Meadowridge
Memorial Park 12-30-2010 Elkridge, MD 4 Donation 5 Other (Specify) of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 2/1227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A proximate erval Between Inset and Death Immediate Cause (Final Physician disease or condition / Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events 012 To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Yes 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 □ No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျ within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28a. Date of injury (Monthy Day, 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: work? 1 ☐ Yes 2 No 1 Natural 2 Accident 5 Pending motor vehicle Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, stc. (Specify) 28f. Location (Street and Number or Rural Route Number determined ROSS 6. 695+5 an Medical 1 Certifying Physician: To the best of my Knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year)

December 24,2010 29c. License number 29b. Signature and title of 053850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Johns Hopkins Bayliew 130 31. Date filed-4 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anita Lynn Kyle Month 2010 8:30 PM December Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Clinton 4c. County of Death Prince George's Examiner Nursing Home and Rehab Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth g. Birthplace (State or Foreign Funeral 07/30/1966 1 □ M 2 🕱 F Days Hours 578-04-7921 43 Director DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Charles Waldorf 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20602 3077 Heathcote Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ō ģ 1 Never Married 2 Married Yes 2 No 3altimore, Maryland 21215-0036 1 Tes 2 No Specify. If Yes, Give Year or Dates Specify: Black "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Sales Agent Real Estate other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H ည Vincent Kyle Maxine Bragdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any Injury or other trau 3077 Heathcote Road Waldorf, MD 20602 Vincete Kyle 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State Final Journey Crem. 2/24/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Borota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Metastatic Onset and Death 'errical Cancer Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IE EEMALE: signed by the attendin 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Yes 2 Julyo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Immunodeficiency Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 N within 24 hours after death.

To the Funeral Director. After this certificate to completed filled in by the funeral director, page 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗡 Natural work?
1 Yes 2 No 5 \square Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) D0053337 December 23 Zelo

Registrar DHMH 17 Rev 7/2009

State

P.O. Box 68760

Smith Avenue Ste 203

Bultinune, Md 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NORRIS KINGSBUR 1935 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY 6. Sex 1 ▲ M 2 □ F If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day Months Days Hours Min MARYLAND Director 578-62-2202 54 Ĩ956 FEB. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tifers 23a or 28a-f sho and tifers 75 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Yes 2 No PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4816 EMO STREET 20743 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married X Yes 2 No NAVY Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH ENTREPRENEUR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ LARSATE KINGSBUR BROWN BARBARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTONIO KINGSBUR/BROTHER 6561 HILL MAR DRIVE #204 FORESTVILLE, MARYLAND 20745 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/10/2010 RIVERDALE, MARYLAND Signature of Funeral Service Licens 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pflysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated sease or impury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ☐ Yes ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 🖺 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ 2 🗌 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 \square Pending Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Me N/A en If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days November 7°, 1959 Australia Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford Maryland Abingdon 1 🗆 Yes 2 🕱 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21009 P.O. Box 665 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life DO, NOT use retired)
Car Salesman 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Be 18. Mother's Name (First, Middle, Maiden Surname) Fotini Kapetanakos 17. Father's Name (First, Middle, Last) မ Elias Kyriakakos 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 5504 Overlook Circle White Marsh Maryland 21162 Athanasia Diakokomninos 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 12/29/10 St. Demetrios Cemetery Cub Hill Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22 Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road B Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final -Physician/ ume disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has performed? Yes 2 N this certificate 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital æ 26. Place of Death (Check only one) 2 🗹 No Hospital: Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Deg State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 23^{Day} Physician/ Month 201 0 Kendall, Sr. Dec. Stephen Lee 8:54 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Hospital Harford Be1 Air 5 Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 5, 1946 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 1 XM 2 - F Hours 218-46-3407 Mary Land Vrs **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Harford Joppa 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 5 10g. Citizen of What Country? must be 23a Funeral 230 Kearney Drive United States 21085 12. Was Decedent Ever in U.S. Armed Forces? ıral", or iter I Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2 五 No If Yes, Give within 72 hours after 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Painter 12 Years Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic eve ၉ Katherine Kubin Paul L. Kendall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo 19a. Informant's Name/Relationship (Type, Print) Joppa, Maryland Stephen L. Kendall, Jr. (Son) 230 Kearney Drive permit. Page 1 and 2 Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 Tacremation 3 ☐ Removal from State Metro Crematory, Inc. 12/31/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final wiluse Ph_sician/ onarstive disease or condition resulting in death) Medical Due to the as a consequence of Examiner rdiovascular Disease erotic Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transi death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No has been signed by the solution 2 should be detached 9 Unknown 9 Unknown Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Tes 2 No Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? 1 Yes Hospital Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, dee id at the time, date and place, and Within 2 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) MD.

State Registrar t filed (Month, Day,

500 Upper Chesapeake Dr. Bel Air, ND 31014

d cause of death (Item 23a) (Type, Print)

Medic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DECEMBER ALICE REGINA LEACOCK 2010 12:05P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year JANUARY 16 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days NEW YORK **Director** 130-24-4748 79 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No GAINESVILLE FLORIDA ALACHUA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3530 N.W. 26TH TERRACE 32605 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates WHITE Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ CECIL JOSEPH DIGBY EILEEN CASE 1 and 2 should to of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5219 IVYWOOD DRIVE SOUTH, FREDERICK, MARYLAND 21703 <u>JOHN D. LEACOCK/ HUSBAND</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date PARKLAWN or other place)
MEMORIAL PARK 1 Burial 2 Cremation 3 Removal from State DECEMBER 29, 2010 4 Donation 5 X Other (Specify) ENTOMBMEN ROCKVILLE MARYLAND Name and Address of Facility ROBER' ROCKVILLE, INC. 3CO ROCKVILLE, MARYLAND A. PUMPHREY FÜNERAL HOME, WEST MONTGOMERY AVENUE 20850-2805 21. Signature of Funeral Service Licenses M00335 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. Life only one cause over chiline. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 been signed by the should be detached g Unknow Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page death? performe 1 Tyes 25. Was case reference Division of Vital Physician: completed filled in by the funeral director, æ 26. Place of Death (Check only one) Hospital Other: 2 🗆 No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Dec 23, 2010 27. Manner of Death 28b. Time of 28c. Injury at Certificate: Hospital or Attending Director: After 5 \square Pending 1. Natural 2 Accident Fell while 9:10 Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of In ury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify, Frederick, mD To the Hospital of within 24 hours a To the Funeral D Ivywood Dr. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the urrie, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce ohr 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 24, 2010 Mary Lambros 5:45 p м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 235 South Clinton Street Baltimore n/a . Age (In *yrs. last birthday)* **86** Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours ADY 11 th 12 y, 1924 Marvil and **Director** 216-24-4060 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 235 S. Clinton Street 21224 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐XNo Specify: White Specify. Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Kortesis Ourania Unknown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 S. Clinton Street Baltimore Maryland 21224 Michael L. J. Lamros/Son 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/29/10 Greek Cemetery Woodlawn Maryland 4 Donation 5 Other (Specify) iednamid jidrikuck^{e sul}inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service-Licens T 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ eno Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Dunknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Dea 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Statural iniury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director; / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and tile of certifier 29c. License number

Registrar

State

31. Date filed (Month, Day,

Year)

28

10

565N. Ch -- 1.)

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	aryland		rtment of tificate of				giene Reg. No.	010	408	342
	Physicia	n/	1. Decedent's Name (First, Middle, La	st)						2. Date of De	ath	Year	3. Time	
	Medic Examin	al	HELEN MIELCZASZ 4a. Facility Name (if not institution, give	e street and number)			4b. City, Town,	or Locati	on of Death	DECEMBEI		010 unty of Dea	1145	5 A M
	Examili	eı	LAUREL REGIONAL HOS				LAUREL	or Locati	on or beauti			NCE GEO		
H	Funeral Director		21311111000	ех	89	t birthday) Yrs.	If Under 1 Yea Months Days		der 24 Hrs. rs Min.	8. Date of Bir (Month, Da JUNE 24	th y, Year) 1, 1921	g. Bii Co	rthplace (State ountry) MD	or Foreign
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	h the l la or 2 be no	al Di	10e. Street and Number				10f. Zip Code				10g. Citizen		ountry?	
	ath wit ms 25 must	Funeral Director	113 NEW JERSEY AVE	12. Was Decedent E	vor in IIS	12 14	2106 as Decedent of		Origin? (Spe	cify Voc or No-	144	USA	-dan Indian	
336	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	Yes, specify Cul	oan, Mex	ican, Puerto			Black, Whit	erican Indian, te, etc. IHITE	
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Maryland 21215-0036	is a sp	7	19a. Informant's Name/Relationship (g Address (Stree				-	ın, State, Z	ip Code)	
	and 2 s Health tem 27		WAYNE S. MIELCZASZ 20a. Method of Disposition	SOI	T		S. WAYNE	AVE.	T	ORO, VA 2		ion - City o	r Town, State	
Ē	Page 1 nent of ant: If it ury or o		1 XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		-		atory`or other pl CEMETERY	ace)		·				
Baltimore,	permit. Page Department of Important: If any injury or once.	4 Donation 5 Other (Specify) HOLY CROSS CEMETERY 12.28.2010 BROOKLYN, 21. Signary of Funeral Service Liceus 22 Name and Edgles of English P. A. 426 CRAIN HWY SW GLEN BURNIE, MD 21061										· ·		1
	23a. Part i Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart salure. List only one cause on each line.												Approxima	ate etween
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л О	that the ned by e detaction	by Pr	Part II. Other significant conditions	ontributing to death bu	ut not result	ting in the ur	nderlying cause	given in F	Part I.	23e. Did to	obacco use o	contribute to	o the cause of	death?
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ř	rsician: The law r s certificate has b lirector, page 2 s		25. Was case referred to medical				26	Place of I	Death (Check		ormed? 212 No		s 2 No	
VIta	is cert direct	To Be	examiner? XX 1 Yes 2 No	Hospital:	ent 2 🗆 EF	R/Outpatient		her:	,	me 5 🗆 Resid	dence 6 \square	Other (Spe	cify)	
101	ing Ph viter th uneral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of injur (Month, Day,		8b. Time of injury		rk?	_	28d. Describe h	now injury oc	curred		
Sior	vttendi death ctor: A y the fi	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not to		rv - At home	e. farm. stre		Yes 2		28f. Location (\$	Street and Ni	ımber or Ri	ıral Route Nun	ıher
UIVISION	al or A s after al Direct		4 Homicide determined	building, etc.		o, rami, odo	ot, radiory, omoc			City or Tov		imber di ric	arar ricute rvarr	idoi,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	sician: To the best of r iner: On the basis of ex se Practioner: To the b	amination a	and/or investi	gation, in my opii	nion, deat	th occurred at	the time, date a	and place, and	due to the	cause(s) and n	nanner stated.
	To the within To the Complete	2	29b. Signature and title of certifier				29c. Licen			5, and due to th			th, Day, Year)	
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	lov		30. Name and address of person who			3a) (Type, Pr	int)							
	Ų V Stat	e .	7300 VAN DUSEN RD. I 31. Date filed (Month, Day, Year)	32 Perietra	r's Signatur	· · · · · · · ·	Mary State Colombia Associate							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Cen	tificat	e of	Death			Re	g. No.		
Physicia	ın/	1. Decedent's Name (First, Mi	Month Day Ye									Year	3. Time of Death 2151 hrs	
Medical Exami	ner	Mustaf					La	City Town	Loggions		December		nty of Death	2131 1115
		4a. Facility Name (if not institu Johns Hopkins Hos		eet and numbe	r) 		4	o. City, Town, o Baltimore					NA	
Funeral Director		5. Social Security Number 214-82-354	6. Sex		ge (In yrs. Ia 43	st birthd	ay) Yrs.	If Under 1 Yes Months Day			8. Date of Birt		Foreign	nplace (State or n ntry) MD
	ŀ	Usual Residence of Decedent	-1											
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with th	al l	11. Marital Status	12	. Was Deceder		S. 1		Decedent of H	spanic Orig			14. Ra	ace - Americ	an Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X	Married 1 Divorced of Year		s? 2 X No			s, specify Cuba Yes 2 X No		, Puerto R	ican, etc.)	- 1		African erican
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MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	Be C	Alexander		Teel						eli		Ven:		
212 ould b d Meni	일	19a. Informant's Name/Relation						Address (Stre	et and Num	nber or Ru	ral Route Num	ber, City or T	own, State,	
ore, MD 2121! ss 1 and 2 should be fil of Health and Mental H If item 27 is marked		Aurelia D. 20a Method of Disposition	Veni	ey-Mo				Carmi			e Bal	timor 20c. Locatio) 21207
Baltimore, Moemit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		1x Burial 2 Cremat	on 3 🗌 F	Removal from S	state Ci	rematory	or othe	er place)						town, MD
Baltimo Department Important:	-	4 Donation 5 Other 21. Signature of Funeral Serv			K	lng		em. Pk						·
Balt permit Departi Importi		Sumerla	ure of Funeral Service Licensee 22 Name and Address of Facility Wylie Funer 638 N. Gilmor Street Balt									Balti	more	, Ma 21217
Physician			Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line.									st, shock, or	heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disea or condition resulting in death	inal disease a Multiple Gunshot Wounds											Death
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760, ficate be g physici the buri	Med	IF FEMALE:		3c. If yes, outcome	ome of pregn	nancy							e of delivery	
		23b. Was decedent pregnant in past 12 months?	1 1	Live birth Pregnant	at time of dea	2 [ath 5	=	al death 3 er (Specify)	Ectopic	c pregnan	су	Month	n D	ay Year
BOX e death the atte	Physician	1 Yes 2 No 9 U	Jnknown 9	Unknown										
s, P.O. Be ires that the de r signed by the	by P	Part II. Other significant con	ditions con	tributing to dea	ath but not re	sulting i	n the un	derlying cause	given in Pa	art I.				he cause of death?
ords, I w requires us been sig should be	ted			-						_	24a. Was a	in 24		opsy findings available
COT s law r s has b	Completed				· · · · · ·						autop	med?	death?	ompletion of cause of
Vital Rec ysician: The l his certificate l director, page		25. Was case referred to med	cal					26. Plac	e of Death	(Check or	1 Yes 2	Z NO	1 🗸 Ye	s 2 No
Vita ysicia this cer direct	To Be	examiner? 1 Yes 2 No	Hospi	ital: 1 Inpat	ient 2	ER/Outp	atient	3 DOA	Other4	Nursing	Home 5	Residence	6 Other	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		27. Manner of Death 1 Natural 5 P	ending	28a. Date of Ir Month, Day Dec 22, 201		28b. Tir 2114 h			ıry at Work Yes 2 ✔	. Is	28d. Describe h ubject shot		curred	
Atten Atten er deatl rector: by the	Certification:	2 Accident In	estigation	28e. Place of	Injury - At ho	me, farn	n, street	, factory, office		c. 2				al Route Number, City
Div	erti		ould not be termined	(Specify) P	arking Lot	t				2	or Town, S 900 block of	ate) Mathews S	treet, Balti	more, MD
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deached for use as	Medical		kaminer;On	the basis of ex	amination ar			ed at the time, on, in my opinio						
To To con	Me	29b. Signature and title of cert		i manner stated	1.			29c. Licen	se number			29d. Date s	signed (Mor	ith, Day, Year)
		affle	Dia.	esse (MI	-		O.C	.M.E.			Decemb	er 23, 20	10
	j	30. Name and address of pers Melissa Brassell, M		oleted cause of			111 D	enn Street, I	Saltimore	e MD 2	1201			
St	ate	31. Date filed (Month, Day, Ye			rar's Signatu		, , , , , ,	Jim Oucet,						
Regist	rar	BEP %	2010	Renows	1.	Jan.	and	1						

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			For State Registrar	State	oi waryian		artment of H rtificate of L		iu ivieii		No		4084	
			Decedent's Name (First, Middle	, Last)						Date of Death	Day	Year	3. Time of Deat	th
	Physicia /Medic		Dolores	Ma	rglo		McAlli	ister		CEMBER	- 20,	2010	7:01A	₹ M
-	Examin	er	4a. Facility Name (If not institution		umber)		4b. City, Town, or		Death		4c. Count	y of Death	h	
and "	Foreset		St. Agnes Hos	6. Sex	7. Age (In yrs.	last birthdav)	BAL77 If Under 1 Year	If Under 24	Hrs. 8. D	ate of Birth		9. Birth	hplace (State or For	reign
	Funeral Director		213-20-2339 Usual Residence of Decedent	1□ M X □ F	86	Yrs.	Months Days	Hours N	Min. O3	Month, Day, Y	24	Con	MD MD	
	yland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Lin	
	e Mar Sa-f s	ctol	MD NA			Balti	more						1 X Yes 2□] No
	with the	Dir	10e. Street and Number 3722 Nortonia	Dond			10f. Zip Code	216		100	Citizen of	What Co		
	eath v	Funeral Director	11. Marital Status		cedent Ever in U	S. 13.1	212 Was Decedent of Hi		? (Specify	Yes or No-			rican Indian,	
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The word the than "natural", or items 23a or 28a-f show umatic event, Its Medical Examinar most be redified at	by Fun	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	Armed	Forces? Sive No Give		lf Yes, specify Cuba 1 □ Yes 💥 □ No	n, Mexican, P Specify:	uerto Ricar	n, etc.)	Bla	ack, White ify: B	e, etc.	
21215-0036	2 hour	ted t	15. Decedent	s Education		16a. Dece	dent's Usual Occupa	ation		16	b. Kind of E	Business/I	Industry	
215	thin 72 e. an "na Madii	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed	(1-4or 5+)	(Give life. I	kind of work done of DO NOT use retired	luring most of)	f working	I	Balti	more	e City	
21	ed wit lygien ner th	Con	12th grade	na			Teacher		/5:				ystem	
and	f be fill intal H ed otl	Be	17. Father's Name (First, Middle, L		a				·	st, Middle, Ma	iden Surna	me)		
Ž	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	٦	Wellington Ma 19a. Informant's Name/Relationsh		Sr.	19b. Mailir	ng Address (Street a	Ella and Number o			City or Town	n, State, Z	Zip Code)	
altimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic ev once.		James McAllis	ter Jr-	Son	4304	Mary Ri	idge I	orive	, Ran	dall	stow	vn, Md 2	1133
ore	of He		20a. Method of Disposition ★☐ Burial 2 ☐ Cremation	3 ☐ Bemoval from	20b. I	Place of Dispo cemetery, crer	sition (Name of natory or other place	e)	Date	20	c. Location	- City or	Town, State	
Ē	t. Pag tment tant: jury o		4 Donation 5 Dother (Sp	ecify)						29/201	O Ow	ings	s Mills,	Ma
Bal	permi Depar Impor any Ir		21. Si nature of Funeral Service L	icansee	h		Name and Address arch F/F) - 1 + i m	020	МА	21215	
i		-	23a. Part / Enter the disease, or	complications that	caused the deat		300 Waba er the mode of dyin					Md	Approximate Interval Between	
-	hysician		shock or heart failure. List of		each line. EUMON	TA							Onset and Death	
	/Medical		disease v ondition resulting death)	a	o (or as a conseq								01142	
	Examiner	_	Sequentially list conditions,	b	,									
	nsit nsit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conseq	quence of):						12.5		
,	executed an and rial-transit	Examin	that initiated events resulting in death) Last	c Due t	o (or as a conseq	quence of):								
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ة ×	ding p	/Mec	IF FEMALE:	230 If yes o	utcome of pregna	anov								
P.O. Box 6876	death certificate be te attending physicia ed for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Liv	e birth 2 🗀 Feta gnant at time of	al death 3	Ectopic pregnancy Other (specify)	/				ate of del Ionth	livery Day Year	
٦. ا	d by the etached	Phys	9 ☐ Unknown Part II. Other significant conditio			sulting in the III	adortving cause give	on in Part I		23e Did toha	CCD USE CD	ntribute to	the cause of death	12
Division of Vital Records,	pures than signed and be det	by	COMGIESTIVE		FAILU		Idenying cause give	enin Paiti.	_				robably 4 Unkn	
O O	aw requir is been si 2 should l	Completed								24a. Was an	24b	. Were au	utopsy findings avail	lable
Ĭ	ate ha	Som								autopsy performe 1 □ Yes 2√	d? ZNo	death?	completion of cause a 2 ⊠No	901
VITA	rnysician: The law this certificate has al director, page 2 s	Be (25. Was case referred to medical examiner?	Hospital:			Othe		Death (Ch	eck only one)				
5	rthis ral dir	:. To	1 ☐ Yes 2 No 27. Manger of Death	N.	Inpatient 2 e of Injury	ER/Outpatier 28b. Time of		4 LI Nursi		5 Residen Describe how			cify)	
<u>.</u>	naing Pn ath. r: After th e funeral	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Mo	onth, Day, Year)	Injury	Work	ć? Yes 2∐No			, , , , , , , , , , , , , , , , , , , ,			
SIAI	To the fraspiral or Artending Prysician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detache.	Certification: To	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Pla buil	ce of Injury - At he ding, etc. <i>(Sp</i> eci	ome, farm, str	eet, factory, office			Location (Stre City or Town,		nber or Ru	ural Route Number,	
_	ours a	al Ce	29a. Certifier 1 Certifying	Physician: To t	ne best of my kno	owledge, deat	h occurred at the tin	me, date and i	place, and	due to the car	use(s) and	manner a	s stated.	
	n 24 h n 24 h ne Fur pletely	edical		xaminer: On the			vestigation, in my o							
i	vithii To th	Š	29b. Signature and title of certifier	T N	FOTCAL	REGIO	ENT PZE	e number		I .	-		th, Day, Year)	
	, ,		Marta					924	\	D	CEMI	SEK	20, 2011	
	6		30. Name and address of person v	vho completed ca	use of death (Iter S CATO)	m 23a) (Type, 4 AVEHU	Print) AE, BALTJ	EMORE	,212	25,	MD			1
	Sta		31. Date filed (Month, Day, Year)		Registrar's Signa									
	Registra	ar	מבר מב	2010	freue	p. 19	are							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 242010 December /Medical County of Death acility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner If Upder Months Birthplace (State or Foreign Country) 1 Year Social Security Number 7. Age (In vrs. last birthdav Date of Birth (Month, Day, **Funeral** 1**∑** M 2□ F Days Hours 078-26-9174 77 New York Director May 26,1933 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rant of Health and Mental Hygiene. The state of Health and Sa or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show thy or other traumatic event, he Medical Espriment in the horitified at uny or other traumatic event, he Medical Espriment in the horitified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 No Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 United States 710 Obrecht Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 √ No Specify Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finances Fundraising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emily Tonnessen Levi W. McCracken ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trau 2902 Krem Ave., St. Louis, MO 63114 Marion Niedringhaus / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 12/27/2010 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor Afakitelo 299 Frederick Rd., Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month 5 Other (specify) 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only of Other: 4 Hospital: 1 Yes 2 → 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) Medical Certification: To filled in by the funeral 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation death. 1 Yes 2 No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Fills

Date filed (Month, Day, DEC 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}26 Physician/ Month 12:30AM M James Edward Mulcahey December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F Months Yrs Director 219-14-7829 86 Maryland Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 4508 Furman Court 20906 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0. 1 Never Married 2 K Married ş 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3
Widowed 4 Divorced Completed Year or Dates. WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 11 Meat Cutter Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Mulcahey Susie Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Elizabeth E. Mulcahey/ Wife 4508 Furman Court, Silver Spring, Maryland 20906 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite Date cemetery, crematory or other place)
Parklawn
Memorial Park 1 X Burlal 2 Cremation 3 Removal from State December 31. 2010 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 2085 Pumphrey Funeral Home/ Montgomery Avenue 50-2805 21. Signature of Funeral Service Licenses M00335 and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Acute Upper GI Bleeding disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury and -transit The law requires that the death certificate be executed Hypovolemic Shock that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown is been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 24 No has 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital: Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pendina s after death.

I Director: Aff d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital within 24 hours To the Funeral I Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

111 State Registrar

29b. Signature and title of certifier SANGEETHA

31. Date filed (Month, Day, Year)

Sangeetha Ranganath,

Box 68760

P.O.

Records,

Division of Vital

D69835

1500 forest Glen Road, Silver Spring, Maryland 20910

2010

RANGANATH

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** December 23, 2010 1:10AM Rita Lorraine Murray /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Wilson Health Care Center Gaithersburg 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1□M 2\ F Hours Yrs. March 29, 1925 85 Director 365-24-9078 Michigan Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 X Yes 2 ☐ No Directo Montgomery Maryland Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 United States <u> 4 Walker Avenue</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elenora Hasselburger Robert Engler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tre Margaret M. Murray/ Daughter 4 Walker Avenue, Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State December 26, 2010 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee Rockville, Rockville, Inc. 300 Maryland M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wecks neumonia **Physician** /Medical Due 1 (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death contificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: for usa 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) o. 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Vital or Attending Physician: 25. Was case referred in medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) 2 No Hospital: Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 0 this 27. Manuar of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? After (Month, Day Year) Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year)
Deamber 23 2010 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Doliniky MO 911 (4956) 20877 32. Registrar's Signature 31. Date filed (Month, Day, Year)
DEC 2 8 2010

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 0330AM **Physician** Marson 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Peswill Minno 3 a N/A If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 0 F 220-05-7193 -05-1920 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County ★X Yes 2 No Director N/A Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 700 W. 40th Street 21211 ural", or items 23a o Il Examiner must be USA 2 should be filed within 72 hours after death and Mental Hygiene.
is marked other than "natural", or items 23 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 🗓 O Baltimore, Maryland 21215-0036 Specify: Specify: white 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any fnjury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William J. Paul Geraldine Riley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daniel Merson Grandson 1387 University Drive, State College, PA 16801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12/29/2010 4 Donation 5 Other (Specify) Lorraine Park Cemetery Woodlawn, Maryland 22. Name and Address of Facility
Burgee Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service Lice 3631 Falls Road, Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Sarcoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause ruisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 1 TYes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy After this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12.27-6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5000 laplins 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla State of Maryla Registrar	•	artment of F			ene 2010	40849
		Ţ	Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physicia Medic		Ellen Meckel				Decembe	1	
	Examin	er	4a. Facility Name (if not institution, give street and number) 4691 Scotsworth Way			Location of Death		4c. County of Dea	^{ath} rro11
2	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	: last birthday)	-	If Under 24 Hrs, Hours Min.	8. Date of Birth	year) g. B	irthplace (State or Foreign ountry) Md .
4	Director		216-36-5148	Yrs.		1100110	07/15/19	939	Md
	land f show d at	tor	10a. State 10b. County 10c. 0	City, Town or Loc					10d. Inside City Limits
	r 28a- notifie	Director	Md. Carroll	Sykes	V111e		1	0g. Citizen of What C	1 🗆 Yes 2 🌌 No
	with th	Funeral	4691 Scotsworth Way		2178	34		USA	ountry:
	death items ner mi		11. Marital Status 12. Was Decedent Ever in U	J.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 Mo If Yes, Give Year or Dates,	1	1 ☐ Yes 2 🕱 No	Specify:		Specify:	White
2 2	2 hour	plete	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occup kind of work done o	ation Juring most of work	ing I	16b. Kind of Busines	
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Maryland 21215-0036	# # F F G	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	, .	aiden Surname)	
yla	uld be fil 1 Mental narked o	2	Gustav Edukat				ne Ridge		
	12 shou lith and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) Roman C. Meckel (Husband)	1				City or Town, State, 2 ${\sf e}$, ${\sf Md}$. 2178	
ore,			20a. Method of Disposition 20b	. Place of Dispo cemetery, cren	natory or other place	e) •		20c. Location - City o	•
Baltimore,	Pag ant	4	4 ☐ Donation 5 ☐ Other (Specify)	arrison	Forest V	ets. 12/		Owings Mil	
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee Blian L. Haigt mo	22 20764 F	2. Name and Addres 20 Box 19	^{ss of Facility} HAI 5 Sykesvi	GHT FUNE 11e, MD	ERAL HOME 21784	& CHAPEL, PA
			23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conse		Onset and Death				
	Examiner)					
	d sit	Examiner	Sequentially list conditions, If any, leading to financiate cause. Enter Underlying	quenne of)*					
	ate be executed physician and the burial-transit		Cause (Disease or linjury that initiated events c. Due to (or as a conservation)	equence of):					
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687	eath certifical attending ph I for use as th	/Me	IF FEMALE: 23c, If yes, outcome of preg	nancy					
Box	death certificate be executed ne attending physician and ed for use as the burial-transi	ician	25b. Was decedent pregnant in the past 12 months? 1	etal death 3 🛚	Ectopic pregnanc Other (specify)	÷y		23d. Date of d Month	Day Year
о. Е	t the d by the stached	Phys	g ☐ Unknown	reculting in the	anderking anyon di	yon in Part I	00 Bidad		and the course of death?
s, P.O	requires that the de been signed by the should be detached	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not r	esulting in the u	indenying cause gro	remmeranti.			to the cause of death? Probably 4 💢 Unknown
org	v requi	olete			-		24a. Was an		autopsy findings available
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ot <	g Phys er this eral dii	e: To	27. Manner of Death 28a. Date of injury	28b. Time of	nt 3 □ DOA 28c. Injury	4 ∐ Nursing Ho / at	ome 5 Reside 28d. Describe how	nce 6 Other (Spe w injury occurred	ecify)
on	tendin leath. or: Aft the fun	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	injury		Yes 2 No			
Division of Vital Records,	l or Att after d Direct d in by	Cert	4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre :ify)	eet, factory, office		28f. Location (Str City or Town,	eet and Number or F State)	Rural Route Number,
_	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Physican: To the best of my kno (Check 2 Medical Examiner: On the basis of examinat						
	o the P	Me	only one) 3 Certifying Nurse Practioner: To the best of 29b. Signature and title of certifier			e time, date and plac	ce, and due to the		as stated.
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		,	30. Name and address of person who completed cause of death (Ite	em 23a) (Type, F	Print)	المناه	Sid	1000 - 1	ND DIZENÍ
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Sig	O CYC	DIEKTOW	DVIC	·, co	ysung 1	110 01184
	Registra		DEC 28 2010 Jenson &	back	2				

10-09436 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Louis J. Monroe State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 8, 2010 **Medical Examiner** 1504 hrs Louis J. Monroe 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 904 South Lakewood Avenue Apt 406 Baltimore 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Months Days Director Hours 1 X M 2 F Yrs 213-32-1878 Marvland () Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked of the Than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be avaisfied at a con-MD Baltimore Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 940 S. Lakewood Street #406 21224 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No 3 X Widowed 4 Divorced Yes, Give Year 1 Yes 2 X No specify: black Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 OR technician hospitals 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk Be Mildred Monroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B 10509 Gentido Court Upper Marlboro, MD Gary F. Monroe/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date permit. Pab.
Department of .
Toortant: If it. crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in 21. Signature of Euperal Service Licensee Ronald 9. Weste State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD art I. Enter the disease, or complications that Physician caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval lure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Course (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED tending physician use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) detached for Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown should be Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed^a death? Yes 2 ✔ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, State 32. Registrar's Signature Registrar

O.C.M.E.

December 16, 2010

			For State	State of Ma	ryland	•	artment of H <i>tificate of D</i>			0.0		11.005
			Registrar 1. Decedent's Name (First, Middle, Last)	<u> </u>		001	timodic or b		2. Date of Deat	eg. No.	3	B. Time of Death
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~	<u></u>		Arden Courts 5. Social Security Number 6. Sex		In vrs las	t birthday)	Pike If Under 1 Year	sville If Under 24 Hrs.	■ 8. Date of Birth		imore	e (State or Foreign
	Funeral Director			M 2 X F	96	Yrs.	Months Days	Hours Min.		, ^Y 1914	Country) Orego	on
	d ow t	_	Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Loc	ection					Inside City Limits
	arylan a-f sh fied a	ecto			roo. Oity,						- 1	1 Yes 2 X No
	the Mi or 28 e noti	ij	Maryland Baltimore 10e. Street and Number			Lill	herville 10f. Zip Code			10g. Citizen of What		
	s 23a	Funeral Director	715 Meadowvale R	Road			21093			U.S.A	. •	
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ev Armed Forces?		13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puert	oecify Yes or No- o Rican, etc.)	14, Race - A Black, W	American I Vhite, etc.	ndian,
036	s after ral", o Exam	ed by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☐XN If Yes, Give Year or Dates,	0	1	☐ Yes 2 💢 No	Specify:		Specify:	Wh-	ite
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Maryland 21215-0036	d be fi Venta arked tic ev	မ	Louis	W.	Buch	ner		C	eleste	Ε.	Dyge	ert
/an	shoul and l is ma rauma		19a. Informant's Name/Relationship (Type	, Print)		19b. Mailin	g Address (Street a	nd Number or Ru	ral Route Number,	City or Town, State	, Zip Code	e)
	and 2 Health tem 27		Carolyn Bartholme 20a. Method of Disposition	Daughter			<u>leadowval</u>	<u>e Road</u>		ille, Mar 20c. Location - City	_	
nor	Page 1 ment of ant; If it		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Qther (Specify)	emoval from State	cer	netery, crem	Nat. Cem	´ !		Arlington		
altimore,	permit. Page Department of Important; If any injury or once,	1	21. Signature of Fine al Service Litensee		AL II.		Name and Addres			on Funera		
m	a m a m	9	Tail Ha	~			1050 York	Road	Towson, i	Maryland	2120	04
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused t caluse on each line.	he death.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	st,	Int	proximate erval Between set and Death
parties of the last of the las	Physician/ Medical		disease or condition resulting in death)	Denent Due to (or as a	ia A	1zhein	ers Type				2000	ears
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876	tificate ng phy as th	Med	IF FEMALE:									
Box 68	ith cer ittendi	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of	☐ Fetal o	death 3 🗌	Ectopic pregnancy	у		23d. Date of Month	delivery Day	y Year
<u>.</u>	sician: The law requires that the death certific certificate has been signed by the attending rector, page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 Pregnant at t 9 Unknown	irrie or dea	aui 5 🗆	Other (specify)					
О	that the	by P	Part II. Other significant conditions conti	ributing to death but	not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribut	e to the ca	ause of death?
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VIta	ysicia s certi directo	To Be	eyaminer?	spital:	t 2 🗆 El	R/Outpatien	Othe	r: 4 Nursing E		nce 6 X Other S	iste	d Living
<u></u>	ng Ph fter thi		27. Manner of Death 1 ↑ Natural 5 □ Pending	28a. Date of injury (Month, Day,		8b. Time of injury	28c. Injury work	at	28d. Describe ho	w injury occurred	20011))	
Sion	ttendi death stor: A / the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At hom	a farm stra		Yes 2 No	006 1		Direct Day	sta Alizanta a
Division of Vital Records,	al or A s after I Direct		4 Homicide determined	building, etc.	Specify)	e, iami, sue	et, factory, office		City or Town	reet and Number or , State)	нигаі нос	ne ivurnoer,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examine	r: On the basis of exa	mination a	nd/or investi	gation, in my opinior	n, death occurred	at the time, date an	d place, and due to t	he cause(s	s) and manner stated.
	To th Within To th Comp	<	29b. Signature and title of certifier				29c. License			9d. Date signed (Mo		Year)
			Joran 18ach	- mD			D006	1199	D	ecember 2	3, 20	010
		-	30. Name and address of person who com				•	0 /105	Тотисор	Marsil and	2120	Ω 4
	Stat	e	Jason Black, M.D. 31. Date filed (Month, Day, Year)	32. Registrar's			St., Suit	e 4103	Towson,	ar Arain	۷۱۷۱ ک	U-T
	Registra		TEC 2 9 2010	1 1 1 1		1 1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 2:19 Рм Hazel Lois Mack Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth Nov. 14,1921 9. Birthplace (State or Foreign Country) Oklahoma 7. Age (In vrs. last birthdav) **Funeral** Days Hours Min. 1 □ M 2 🖵 F Yrs. 89 Director 214-44-2867 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No MD Baltimore Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 334 Stevenson Lane 21286 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify. white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meone. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Franklin Walker Margaret Mae Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Lois Mack / daughter 334 Stevenson Lane Apt. C1; Towson, MD 21286 Itimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🖸 Cychoation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Donate (Specify) illtop Service Corp. 12/30/2010 Towson, MD 21. Signature of Funer 22. Name and Address of Facility 1050 York Road Towson, MD 21204 <u>Ruck Towson Funeral Home,</u> Inc. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause in part of the complex of t aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Gause (Disease or imjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 3 Probably 4 Unknown 1 Yes 2 No Be Completed this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Spe 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) eral Certificate: Manner of Death 28b. Time of 28c. Injury at Affer 5 \square Pending in 24 hours area and he Funeral Director: Africated filled in by the fun Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 🕽 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit 29c. License numbe of person who completed cause of death (Item 23a) (Type, Print 30. Name and address 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Leo Anthony Norton Sr. DECEMBER 34, 3010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITA(BAltimore BAITMORE SINAI If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Year) Days **№** М 2 🗆 F MD 219-28-1327 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Department of Health and Mental Hygiens.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, it is Madical Experience; ast by nutilized at once. Lochern MD Baltimore 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21244 8012 Parks Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Automative Retailer 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Norton ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Delaphine Norton-Wife 8012 Parks Lane, Lochem, MD 21244 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State at Park 12/31/2010 Woodlawn, MD 22. Name and Address of Facility White Fineral Home P.A. of Politimere Co. King Memorial Park 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Par/1. Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reart **Physician** NOSCH /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to terminate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: law requires that the death certificate be executed burial-transi Due to (or as a consequence of): certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐Yes 2 No e Hospital or Attending Physician: 24 hours after death.
Pruneral Director: After this certificaletely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) To the within 2.

29c. License number

SINAI

H006810

29d. Date signed (Month, Day, Year)

HOSPITAL OF BALTIMORE

24,2010

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRISCILLA MISHOGAN DIO.

30

32. Registrar's Signature

Lec Norto

Low

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 25, 2010 10:21AM Northcutt Loretta Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson Date u. (Month, Day, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 6. Sex **Funeral** 8. Date of Birth Months Days 1 🗆 M 2 🕱 F Day, Year) Director 144-32-1198 70 Aug Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Examiner must be notified at Director or 28a-f 1 Tes 2 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12202 Burncourt Road, unit 101 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 04 Education Teacher Be aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ryszewski Edward Kurek Elizabeth L. ift. Page 1 and 2 shours out of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Thomas Northcutt, III/Husband 12202 Burncourt Road, #101, Timonium, MD 21093 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/10 Atlantic Crematory Glen Burnie, Maryland 21. Signature of Functal Service Liceuse 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 chael G 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Sepsis secondary to bacteremia EMRSA and VRE from the to (or as a consequence of): Physician disease or condition resulting in death) i month Medical ine sepsis/infected Examiner I month Skin wounds E anuvia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Chronic, uncontrolled Atrial fibrillation month Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical month pulmonary hupertension Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregna

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Year signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes mellitus, morbid Decubitus ulcers, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Obesitu autopsy performed certificate Yes 2 No Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one D0065809 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St., Towson MD 21204 maano State

DHMH 17 Rev 7/2009

Registrar

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			State Registrar		Cei	illicate t	or Death	2. Date of De	Reg. No.	10	3. Time of Death
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Bal	permit. Page Department of Important: If any injury or once,		21. Signature of guneral Service Licens	m. Lonken				11824 Re OME Reiste			oad 21136
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Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome pf pregna 1□Live birth 2□Fetal	death 3	⊒Ectopic pregr				ate of delive	ery Day Year
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P.0	that the de ed by the detached	Ph	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the u	inderlying caus	e given in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
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o	Phys r this ral di	. To	27. Manny of Death	28a. Date of Injury	ER/Outpatier 28b. Time o		Injury at Work?	sing Home 5 Res	how injury occu		у)
Division	Attending I r death. ector: After by the funer	tion	1 Valatural 5 ☐ Pending investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ N	lo			
/iSi	l or Attendafter death Director:	fica	3 Suicide 6 Could not be	28e. Place of injury - At ho	me, farm, st	reet, factory, of	ffice			nber or Rura	al Route Number,
Di	al or saffer al Dire	Certification:	4 Homicide	building, etc. (Specify	7			City of To	own, State)		
	bours hours unera ly fille			/sician: To the best of my know							
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Medical	one)	and manner stated.	ion anu/or II	_		in occurred at the time			
	To t To t	Σ	29b. Signature and title of certifier				icense number	N .	29d. Date sign		
						50	52740		12-	27-1	V
_		1	30. Name and address of person who o	completed cause of death (Item	23a) (Type,	Print)	3				- 1

State Registrar

January Mingark ms.
31. Date filed (Month, Day, Year) 9.32. F

DEC 282010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 11:30 AM erenc December 3, 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (State or Foreign Hours 215-40-30 75 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√∑ No Anne Arundel Glen Burnie MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA 340 Thelma Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.Bnk Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No white Specify: 3 Widowed 4 Divorced unk 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 899 Cecil Avenue S Millersville, MD 21108 of Disposition (Name of Disposition (Name of Disposition (Name of Disposition)) Genesis Knollwood Manor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4□Donation 5₩0ther (Specify) in state 21. Signature of Funeral Sur 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Can (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it at y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

Be 2

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or rother traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

The law requires that the death certificate be executed as the burial-transit and signed by the attending physician if be detached for use as the buria been si should I has

Exami Physician/Medical þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 2 Certification:

Division or Vital Records, P.O. Box 68760,

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ o 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery Month Day Year
	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
1 Yes		1 Yes 2 No 3 Probably 4 onknown
		24a. Was an autopsy autopsy performed? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	26. Place of Death (Check only one)	
	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide Getermined	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occurred at the time, date and place, ar niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

29d. Date signed (Month, Day, Year)

Drew Chate MD 21419

State Registrar

31. Date filed

(Check only one) 29b. Signature and little of cer

28

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death? Physician/ Month Yĕar O) (onner Timothy 2:24 A December Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice at NW Hospital Baltimore Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 05/05/1936 Director 318-30-7103 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits with the Maryland notified at Director MD Howard Columbia 1 X Yes 2 No 10e. Street and Number or 10f. Zip Code 10g, Citizen of What Country? event, the Medical Examiner must be Funeral items 23a 21045 U.S.A. 7080 Cradlerock Way #303 id be filed within 72 hours after death wental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 X Yes 2 \(\subseteq \text{No Army} \) Black, White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than 'any injury or other traumatic event, the Mean once. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eva Faragoi Timothy P. O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8937 Footed Ridge Columbia, MD 21045 Tajuana Sanders / Daughter-Law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/29/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services 21. Signature of Funeral Service Licensee michael P.O. Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ lung concer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other:
4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) NSKNjapahreM.D 00057465 12/23/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Av. 5-203-Baltimore, Mb. 21205 N.S. Rajapakse, M.D. 31. Date filed (Month, Day, Year) 32. Regi trar's Signature State Registrar

amend #8 Per FH G911 1/03/2011 III of Health and Mental Hygiene amend #7 Per FH G911 1/10/2011 III of Health and Mental Hygiene Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Conth Physician/ 618 OLIVE 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Forest Park Baltimore Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 1928 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Country) 82 MD Director Yrs. Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location be filed within 72 hours after death with the Maryland altimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21215 Park orest US4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1,4 or 5+) Bethlehenn Crane C Devator 12th arade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Oliver FONKES ttathe permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Park Maude Oliver Avenue 13attimore MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Owings Hills, LD 0105/2011 4 ☐ Donation 5 ☐ Other (Specify) gamison Forest C. Eyelene Funeral Services any inj once. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughn Road Randallstown MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ARKINSONS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence or) Harry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year Pregnant at time of death ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Nc 24 hours after death. Funeral Director: After this certificate has 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural iniurv 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1303 AUIA 31. Date filed (Month, Day, Year) trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O'Rourke 19. 2010 8:59 ΡМ George December Donald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours January 26, (ear) 1929 New Jersey 81 **Director** 205-24-1801 Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Gaithersburg 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 United States 442 Leaning Oak Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gerald John O'Rourke Ruth Elga French 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 442 Leaning Oak Street, Gaithersburg, MD 20878 Joan M. O'Rourke / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 22. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Years Physician/ Cancer of the Tongue disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical that the death certificate be ending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 N Other (Specify) Hospice 1 ☐ Yes 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA 10 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760 P.O. ospital or Attending Physician: The law requires hours after death.
Incral Director, After this certificate has been sign diffied in by the funeral director, page 2 should be Records, of Vital Division To the Hospital or within 24 hours at To the Funeral D

Baltimore, Maryland 21215-0036

10V

State Registrar

Medical

4 Homicide

29b. Signature and title of ce

30. Name and address of

29a. Certifier

person who completed cau

determined

rtifier

e of death (Item 23a) (Type, Print)

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1355 Piccard Drive, Rockville, Maryland 20850

29c. License number

D37142

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

December 20, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 10860 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0'Brien 2010 Vivian 11:25 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Street Hart Heritage Estates Social Security Number If Under 1 Year 7. Age (In vrs. last birthday If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 💢 F Days Hours 02701/1924 Director 86 MD 215-22-0041 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be matter at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 23 North Kelly Avenue 21014 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physical Research 12 5+ Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Schlarb 0'Brien Myrtle Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 976 Chesney Lane, Bel Air, MD 21014 Luella Boin, Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Hilltop Svc. Corp. 12/28/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ YEARS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine riany, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day 1 ☐ Yes 2 ☐ g ☐ Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy • Hospital or Attending Physician: The I 24 hours after death.
• Funeral Director: After this certificate h performed 1 Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 other (Specify) 2 1 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 🗆 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number D39889 necense- 27, 2016 MA MACPHAIL BELDIN MD. 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

20V

SPARKS

DIGRAD 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DECEMBER 2010 4:50 PM POPE MINNIE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON STELLA MARIS If Unde If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex Age (In vrs. last birthday) 8. Date of Birth Months 1 🗆 M 2 🗶 F JULY 18, Year 1923 **Director** VA 217-26-0746 87 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1X Yes 2 ☐ No BALTIMORE TURNER STATION 10e. Street and Number 10g, Citizen of What Country? Funeral items 23a 21222 USA 633 AVONDALE RD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 👿 No Specify: Specify: BLACK 3 ☐ Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWORK Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MARY DODSON AWRENCE WILSON Health and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVONDALE RD. BALTIMORE, MD ROCHETTE POPE/DAUGHTER 665 N. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STANISLASUS CEM. 12-30-2010 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line EREBROUA Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to in medi-cause. Enter Underlying Due to for as a nonsequence on use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 🗌 Yes 1 Yes 2 No of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 4 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Suicide
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day) Year State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2010 10:06 PM Emmitt Perry III Dec 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ste. Agnes Hospital 7. Age (In yrs. last birthday) 51 Yrs. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Days 1**X** M 2□ F Months Hours Min. 213-78-3537 Director 1-11-1959 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the motified at Director 1 ☐ Yes 2 No Gwynn Oak Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21207 USA 1404 Clairidge Road 7 is marked other than "natural", or items 23a traumatic event, the Western Exert it annuals Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White, etc.
African-American
Specify: within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Ye ar or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Dept. Of General Services Truck Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Hubbard Emmitt Perry Jr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Clairidge Road, Gwynn Oak, MD 21207 Denise R. Coles-Perry/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hartswell Baptist Church 12/31/2010 Ottman, Virginia 21. Signally of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** Squamous cell disease or condition resulting in death) carcinoma of the liene 4 months /Medical Due to (or as a consequence of): metastanis Examiner Heme of the Secondary to saleamers cell Due to (or as a consequence of): 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Hospital or Attending Physician: The 2 ☐ No Vital 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To of Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Medical resident PGYI Dec, 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 5 caton Avenue, Baltimore MD 21229 Priyaa Viswanakan MD 31. Date filed (MUTE Cay, 2°68) 2010

State Registrar

monit

Permy.

3. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #9 Per FH Per FH G911 1/6/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BRENDA PETERSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEDICALO ENTER BALTIMORE MOPKING BAYVIEW 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Year) - 1<u>951</u> 233-84-5306 Months Hours Min 59 **Director** Maryland Usual Residence of Decedent shov 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3405 Walbrook Avenue 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Specify: 3 Divorced 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ial Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Service Station Attendant Fuel 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles A. Shupp Nellie R. Firl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Danesie /sister 101 Center Place Baltimore MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 12/29/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fineral Service Licenses 22. Name and Address of Facility 300 Mace Ave. BAlto MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ESPIRATORY Onset and Death Physician/ FAILURE disease or condition resulting in death) INKNDWN Medical Due to (or as a consequence of) Examiner UNKNOWN Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACCIDEN EREBADYASLULAR Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown DIABETES MELLITUR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cortifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BHARAT SINGH, 4940 EASTERN AV, BALTIMORE, MD, 21224

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:15 PM Charles O. Pamplin Jr. DECEMBER 2010 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes BALTIMORE hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March9, 1948 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Months Days Hours **№** M 2 🗆 F 62 228-62-6098 Director MD Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Examiner must be notified at 1 ☐Yes 21 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Edmondson Avenue USA 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?
1 XYes 2 □ No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, Its Modical Evantional. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: White ģ 3 ☐ Widowed 4 🏿 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Painter 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles O. Pamplin Sr. Margie J. Soloman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Healt: Important: If item 27 any injury or other tr once. Nora P. Davis /sister 1632 Cross Winds Road Myrtle Beach SC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 12/21/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD re of Funeral Service Licensee 2 Signal Connelly Funeral Home of Essex In 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC **Physician** 1 DAY SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NEUMONJA WEEKS Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami the burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tunknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 212No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2**√**2√No Nation 2 ER/Outpatient 3 DOA Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

P.O. Box 68760, Records, Division of Vital ie Hospital or Attendi 24 hours after death. e Funeral Director: 4 To the Hosp within 24 hor To the Fune completely fi

the Maryland

Baltimore, Maryland 21215-0036

28a-f show

23a or

or items,

State Registrar (Check only one)

29b. Signature, and title of certifler

MEDICAL RESIDENT

and manner stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 2010 December, 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE, 21229 PATEI S CATON AVENUE

31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 3:57 PMM December James Phelps Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Takoma Park <u>Washingto</u>n Adventist Hospital . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F Months Days Hours Min. Apr 19, 1945 California Director 65 219-48-8590 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring MDMontgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 2816 Gracefield Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Washington Adventist College (1-4 or 5+) Elementary/Seconday (0-12) groundskeeper Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary PHelps James Phelps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 6810 Eastern Avenue NW Washington, Dc 20012 Pastor Gerald Fuentes Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🔀 Other (Specify) ature of Funeral Sen Ronal State and Andrew Street 855 W. Baltimore Street Baltimore. MD 21201 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mi or beart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Medical Due to (or Examiner Sequentially list conditions, Examiner rany, reaumy to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown ntributing to death but not resulting in the underlying cause given in Part I Part II. Other significant 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performe 1 ☐ Yes 2 ☐ No 25. Was case ref ed to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 2 LNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 \square Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending death. 1 Yes 2 No Investigation Accident within 24 hours after death

To the Funeral Director:
completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License numbe 29d. Date signed (Month,

State Registrar 7701 Carroll AVE Takoma Park, MD

20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Nasreen Mustafa Kango

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Willie B. Plummer 2010 William December 6:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Golden Living Center Westminster Carroll If Under 1 Year If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 🗆 F Months Days Hours (Month, Day, Year) an. 6, 1922 **Director** Virginia 88 231-14-7474 Jan. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State id be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🔀 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 New 21136 Avenue U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 x Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify. 3 Widowed 4 Divorced Year or Dates WWII White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Concrete Foreman Gray & Son Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည E. Lyda Plummer 0ra Mae Sebastian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy L. Plummer Wife 109 New Avenue Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem Gardens 12/30/2010 Finksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNERAL HOME Reisterstown M 10 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) eumon Medical Due to (or Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year g Unknown 9 I Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b lirector, page 2 sh 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be director. 26. Place of Death (Check only one) Hospital Other: မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural injury 5 Pending work?
1 Yes 2 No I Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined n 24 hours af ie Funeral Di oleted filled ir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signatt 29c, License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

282010

Poole Rd. Westmin ster

d address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D**2**4 20**1**0 Physician/ December 4:32 Shirley Ann Quinter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Sept 22 Year) Maryland Months Days Hours Min. 1 🗆 M 2 😾 F 218-46-4250 64 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10c. City. Town or Location 10a. State 10b. County Director 1 🗌 Yes 2 🔀 No Cecil Rising Sun 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral **USA** 21911 75 Roop Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ည Jeanette Kelly Helen Elie Ellsworth Leuba 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, 75 Roop Rd. Rising Sun, Md. Mr. Stephen W. Quinter/ Hus. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12-27-10 Towson, Md. Hilltop Service Co. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of uneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final concer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death Day in the past 12 months?

1 Yes 2 No Pregnant at time of death been signed by the a should be detached to g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>à</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No cate has l page 2 s 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖹 No ျ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [within 2 only one

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wes

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Roche 21 2010 stuart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AUGSBURG 5. Social Security Number BO_1+1 timore Werrentus Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sex 1 M 2 F **Funeral** Days Hours Min 59 219-58-3510 INDIANA Director 6/6 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exyminer must be notified at 1∏Yes 2∏No Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 2700 KEN OAK 21215 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I XYes 2 □ No
If Yes, Give 1971-73
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event MNTNCE TECHNICIAN BALTIMORE CITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERBERT ROCHE ALMA WARD ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2700 KEN OAK; BALTIMORE, MD 21215 HERBERT ROCHE/FATHER Baltimore, 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 01-03-2011 OWINGS MILLS, MD 21. Sign wife of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTIMORE, MD 21217 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or miury Examiner Due to (or as a consequence of): requires that the death certificate be executed Causs (Disease or inju that initiated events resulting in death) Last and burial-1 Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical attending esn. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 No the 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No Division of Vital e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Campfield Rd Baito MD BIRCH CRNP REGINA 1180

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 28 20

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 21/2010 Marie Robinson 12:58pm[™] Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Days (Month, Day, Y 8/18/14 Months Hours Year) 218-18-9305 96 Director MD Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Directo MD Baltimore 1 √Yes 2 □ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 1023 Marleigh Circle 21204 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 🗓 o Black, White, etc. 1 Never Married 2 Married à Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) other than Elementary/Seconday (0-12) e 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other tha College (1-4 or 5+) Model Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Alexander Doda Anna Kuscak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heaith ar Important: If item 27 is any injury or other tra Carol A. Seaman / Daughter 1021 Marleigh Circle, Baltimore MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other p 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State Ardent Crematory or other property 12/23/2010 Hanover Maryland 4 Donation 5 Other (Specify) seeVictor P. Doda, Jr 22. Name and Address of Facility
Charles L. Stevens Funeral
1501 Fast Fort Avenue. Balt Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical IF FEMALE: f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year or Attending Physician: The law requires that the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗆 No 3 🗆 Probably 4 🗡 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' this certificate 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 흗 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After I Natural 5 Pending work? 1 🗌 Yes 2 No Investigation Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗠 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 TOUSON M 10 32. Registra State Registrar

DHMH 17 Rev 7/2009

Baltimore.

Box 68760

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 ☐ No 100 and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 No 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO MGT use retired) 15. Decedent's Education (Specify only highest grade completed) Important: If item 27 is marked other than 'any injury or other traumatic event, the Mee once. College (1-4 or 5+) filed within Be 18. Mother's Name (First, Middle, M Page 1 and 2 should be 19b. Mailing Address (Street and <u>Num</u>ber or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date/ Burial 2 Cremation 3 Removal from State Burial 2 L. Gremation 4 Donation 5 Donation 5 Other (Specify) 21. Signative of Funeral Service Linensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a const quence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury To the Hospital or Attending Physician: Telaw requires that the death certificate be executed the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Ectopic pregnancy Month Dav 5 Other (specify) 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ge 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown pee 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate it 2 1 No director, p 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. injury at 28d. Describe how injury occurred 1 Matural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0062689 December 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen L. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

10-09882 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Walter Ritter State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ December 22, 2010 Medical Examiner Walter Ritter 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 663 East Clement Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 213-36-2919 1XXM 69 04/19/1941 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County s 23a or 28a-f show e notified at once, N/A or 28a-f show MD Baltimore City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 663 East Clement Street 21230 United States 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, , or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Vac Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygeine.
Important: If item 27 is marked other than "natural", o
injury or other transmite evect, the Medical Examiner. 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Parks & Recreation Baltimore City 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ernest Ritter Martha LaBarre 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore Ritter Sr. / Brother 405 Walnut Grove Rd., Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc 12/27/2010 Baltimore, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, MD 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Medical a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ≛xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death 2 past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown for 9 Unknown the Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24a. Was an this certificate has performed? ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medica æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ✓ Yes 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 V Natural 5 Pending 1 Yes 2 No the 2 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide (Specify) Homicide

23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Other Nursing Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 23, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, 32. Registrat's Signature State Registrar **ORIGINAL**

3 Time of Death

1835 hrs

Country) Maryland

10d Inside City Limits

1 Yes 2 No

Approximate Interval

Between Onset and

Death

Foreian

White, etc.

White

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 18, Physician/ December 2010 W. Sr. 2:46 AM Nelson Rupp, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3620 Littledale Drive #113 Kensington Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Ohio Months Days Hours August Day 2 (ear) 1917 93 274-16-3976 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland| Montgomery Kensington 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral 23a 3620 Littledale Drive #113 20895 United States items hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò ò 1 Never Married 2 X Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates. 1945–69 Specify: White 'natural", Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy Dental Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charlotte Eddy Edson Coldren Rupp permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson W. Rupp, Jr./ Son 4104 Dana Court Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 23. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington, Virginia 2011 Arlington National Cemetery 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc
7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Fuyleral Service Ligensee MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Vascular dementia disease or condition resulting in death) Years Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death:

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transi Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav 1 Yes 2 No detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Chronic Kidney Disease 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work' 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

31. Date filed (Month, Day, Year) State DEC 28 Registrar

Geoffrey Coleman, M.D. 1355 Piccard Drive Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D37142

12-20-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 40873 Certificate of Death 2. Date of Death 3. Time of Death Physician/ Dav KIANC 320 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospital Center Westminster Carroll 8. Date of Birth 0(Month, Day, Year) 0Ct • 26, 1932 Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 M 2 X Director 215-32-4138 78 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carroll 1 ☐ Yes 2 🌠 No Sykesville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5416 Irving Ruby Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 V No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vandever Myers Louise Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ivan Rash (Spouse) 5416 Irving Ruby Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Lake View Mem. Park | 12/31/2010 | Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee Duan PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician Medical Examiner

Baltimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director: A completed filled in by the fi

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition resulting in death)	Breast Cancer				Onset and Death						
		Due to (or as a consequence of):										
amine	Sequentially list conditions, if any backing to in modiate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Existic (or ea a nonesquence of):										
dical Ex	resulting in death) Last	Due to (or as a consequence of):										
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of de Month	delivery Day Year									
Be Completed by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 yes 2 No 3 P Pulmo nan lubolum 24b. Were au autopsy											
Somple	Tulmo	Tulmonay lmbolion 24a. Was an autopsy performed? death? 1 Yes 2 No 1 Yes										
Be (25. Was case referred to medical examiner?	2	ace of Death (Check or	nly one)								
ျ	1 L Yes 2 LLUNO	ospital: 1 Impatient 2 I ER/Outpatient 3 I DOA	er: 4 🗌 Nursing Home	5 Residence	6 Other (Spec	cify)						
ficate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury work injury M 1										
Medical Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ral Route Number,									
Medica	(Check 2 L Medical Examir	cian: To the best of my knowledge, death occured at the time er: On the basis of examination and/or investigation, in my opinion Practioner: To the best of my knowledge, death occurred at the	on, death occurred at the	e time, date and place	ce, and due to the	cause(s) and manner stated.						

12,27,2010

State Registrar

only one) 29b. Signature

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		irtmen tificate			and M	lental Hy	giene Reg. No.	10	408	374	
F	Physicia		Decedent's Name (First, Middle, Las AMY RILEY STEVENS	t)							2. Date of Dea		0 Year	3. Time of 915	f Death	
1	Medic Examin		4a. Facility Name (if not institution, give	street and numb	er)		4b. City, 7		Location o	of Death		4c. Coun	ty of Death		F	
	Funeral Director		5. Social Security Number 6. S 217.26.4219	эх П м 2 Д F	. Age (In yrs. Ia	as <i>t birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Dat DEC 23,		9. Birth Cour	place (State o	or Foreign	
Aaryland	Ba-f show tifled at	Director												10d. Inside Ci	ity Limits	
with the N	s 23a or 2 nust be no	Funeral Di	10e. Street and Number 613 OPEL RD.				10f. Zip	Code				_	of What Country?			
036 s after death	and wental Hygelee. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	12. Was Decede Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? XX No	If	/as Decede Yes, speci	fy Cubar	i, Mexican	, Puerto f	cify Yes or No- Rican, etc.)		ace - Americ ack, White, fy: WHIT	etc.		
Maryland 21215-0036 2 should be filed within 72 hours after	ne. than "natur ie Medical	To Be Completed	15. Decedent's E (Specify only highest grade) Elementary/Seconday (0-12)	ducation		life. DC	ind of work NOT use	Occupa done di retired)		of workir	ng		Business In	usiness Industry		
land 21 be filed with	ental Hygle ked other i ic event, th		17. Father's Name (First, Middle, Last) JOHN E. RILEY			HU	MEMAKE	.K			(First, Middle,	OWN HO				
S 01 =	r hearn and wen item 27 is marke other traumatic	5-2 77	19a. Informant's Name/Relationship (T) DAVID STEVENS	rpe, Print)	SON				nd Numbe	r or Rural	Route Number	r, City or Town,	State, Zip	Code)		
5 5 7	O		20a. Method of Disposition 1 ☐ Burial 2 (A) Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	sition (Name atory or oti MATORY	her place		12.28	ate . 2010	20c. Location	ORE, M						
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N	sician/ ledical aminer	8 9	23a. Party, Enter the disease or companies shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ne cause on each	used the death line. as a consequ	ark	r the mode				respiratory arr	est,	-	Approximat Interval Bet Onset and I	ween	
		Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury	b. Due to (or	as a consequ	ence of):										
60 ate be executed	ohysician and the burial-transit	dical Exa	that initiated events resulting in death) Last	ence of):	i:											
. Box 6876 (he death certificate	To the Funeral Director: After this certificate has been signed by the attending ple completed filled in by the funeral director, page 2 should be detached for use as the funeral director.	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date								ate of deliv	•	'ear			
dS, P.O.	en signed b ould be deta	þ	Part II. Other significant conditions co		/		derlying ca	ause give	en in Part I			bacco use con				
Mecor The law re	cate has be , page 2 sho	Completed		neun	onia						24a. Was a autop perfor	sy med2	Were auto prior to co death? 1 Yes	psy findings a mpletion of ca 2 No	vailable ause of	
OT VITAI Physician	r this certifi eral director,	P B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Yo 27. Manner of Death	Hospital: 1 ☐ In 28a. Date of	patient 2 1 injury	ER/Outpatient 28b. Time of	$\overline{}$	Othor	4 Nu	rsing Hor	only one) ne 5 Resid 8d. Describe he)		
DIVISION OT VITAI RECONDS, tal or Attending Physician: The law requires after death.	irector: Afte n by the fund	Certificate:	1 Statural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Day, Year) Injury - At hor, etc. (Specify)		М	work?		No	28f. Location (S City or Town	treet and Numb		Route Numb	er,	
e Hospital o	e Funeral D	Medical C	29a. Certifier 1 Certifying Phys (Check 2 Medical Examionly one) 3 Certifying Nurs	ner: On the basis	of examination	and/or investig	gation, in m	y opinior	i, death oc	curred at t	he time, date ar	nd place, and di	ue to the car	use(s) and mar	nner stated.	
To th withir	To th comp		29b. Signature and title of certifier Solution 1995 30. Name and address of person who certifier				29c.	License			1	29d. Date signed	ed (Month, I	Day, Year)	10	
7	Stat		30. Name and address of person who c	866/ V	of death (Item	23a) (Type, Pr	int)				le M	D 21	108	>		
JUMU 1	Registra	~	31. Date filed (Month, Day, Year) DEC 2820	10	and .	1 6	Carla	_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 8:31am Physician/ Louis E. Schwanke Month 12/27 /2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Anne Arundel 4b. City, Town, or Location of Death Glen Burnie **Examiner** Baltimore Washington Medical Center Social Security Number Birthpia Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-28-4243 1 **X** M 2 □ F Months Days Hours Min 9/20/1929 81 **Director** Usual Residence of Decedent or 28a-f shov notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director MD N/A Baltimore City YX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1278 Riverside Avenue 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1

✓ Yes 2

✓ No Black, White, etc. ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 5-0036 White 1 ☐ Yes 2XXNo Specify: If Yes, Give Completed 3 X Widowed 4 ☐ Divorced US Army Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) Longshoreman Shipping 8 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis A. Schwanke Mary Elizabeth Owings traumatic 19a. Informant's Name/Relationship (Type, Print)
David L. Scott / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1278 Riverside Avenue, Baltimore MD 21230 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Glen Haven Cemetery 1XXBurial 2 Cremation 3 Removal from State 12/30/2010 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home, Ir 1501 East Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Arcal 17119 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but net resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown icate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy After this certificate Yes 2 XN 25. Was case referred to medical examiner?

1 Yes 2 No Be (completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Certificate: To 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred iniury 5 Pending 1 ☐ Yes 2 ☐ No s after death. 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 281 1105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14.00 1das 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

		1	Ple	ase Type or Pri					_	jible.			
			For State Registrar	State of M	laryland / Dep Ce	partment of F ertificate of L			giene Reg. No.2 ()	10	40876		
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	Examin	er	4a. Facility Name (if not institutio	Itospital	" I bid day	Randa	r Location of Death 11stown	1		ltimo			
	Funeral Director		5. Social Security Number 217-09-9419 Usual Residence of Decedent	6. Sex 7. Ag	ge (In yrs. last birthday) 94 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 12/03/		9. Birthp Count	place (State or Foreign try) MD		
	ryland I-f show ied at	Director	10a. State 10b. County	,	10c. City, Town or L				10d. Inside Cit				
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920	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☒ Widowed 4 ☐ Divorce	111/1 100	Ever in U.S. 13.	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	ce - America ck, White, e Whi	etc.		
21215-0036	n 72 hou e. an "natu Medica l	Completed		ent's Education hest grade completed) College (1-4 or 8	(Give	edent's Usual Occup e kind of work done o DO NOT use retired)	during most of worki	ing	16b. Kind of B	lusiness Inc	lustry		
21	l within ygiene her th t, the		12	ne	BGE								
Maryland	d be filed Mental Hy Irked oth tic event	To Be	17. Father's Name (First, Middle, (Unknown) G	•			18. Mother's Nam Lucill	e (First, Middle, Le Geis]		e)			
Mary	1 and 2 should be file of Health and Mental I item 27 is marked of other traumatic eve		19a. Informant's Name/Relations			er, City or Town, S	. ,	ode)					
ď	1 and of Heali item 2		Helen Townsend/Friend 3614 Langrehr Rd., Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, St										
Baltimore,	t. Page tment c rtant; If ijury or		1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier Oueen Funeral Home & Crematory,										
Bal	permil Depar Impor any in		21. Signature of Funeral Service	Licensee	2								
			23a. Part 1. Enter the disease, or	or complications that caused only one cause on each line	d the death. Do not en		Old Liber			.10, 11	Approximate		
- 4	Pnysician/	0 0	Immediate Cause (Final disease or condition	Chron		nctive	Pulmona	m Do	ease		Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as	a consequence of):	ation	estimate de la constantina della constantina del	,					
	executed ian and urial-transit	Examiner	S _ uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	· Prievo	a consequence of):								
	cate be execut physician and the burial-trar	edical		d									
. Box 687	Hospital or Attending Physician; The law requires that the death certificate be 24 hours after death. 124 hours after death. 124 hours after death. 135 hours after death. 146 hours after death. 156 hours after death. 157 hours a breath. 158 hould be detached for use as the but t		IF FEMALE: 23b. Was decedent pregnant in the past 12 movins? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	су			ate of delive	ery Day Year		
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Division of Vital Records,	The law requires ate has been sig bage 2 should to	Completed						24a. Was autor perfo 1 Yes	psy ormed?_	Were autop prior to con death? 1 \(\subseteq \text{Yes} \)	osy findings available mpletion of cause of		
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Divisi	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page		3 Suicide 6 Could 4 Homicide deterr	d not be mined 28e. Place of Inju building, etc	ury - At home, farm, st c. (Spec <i>ify)</i>	treet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural	Route Number,		
)	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	examination and/or inve	estigation, in my opinio	on, death occurred at	t the time, date a	and place, and du	e to the cau	ise(s) and manner stated.		
	Voith To th		29b. Signature and title of certifie	Me		29c. License			29d. Date signe				
	(30. Name and address of person	who completed cause of d	leath (Item 23a) (Type,	μ Print)	ψ6453	0	DECEN	186R	26,2010 MD 21133		
	5 V		KEVIN-SEAN / 31. Date filed (Month, Day, Year)	A. MGANN	, 20 51	401 010	d Court	Road, 1	Randal	Istour	, MD 21133		
	Stat Registra	re.	131. Date filed (Month, Day, Year)		ar's Signature	0.4.1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 23a per dr., g910, 12/28/2010 dhb Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 09:40 PM Dec 10 Leon Stewart 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Hospital St. Agnes If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 9 / 2 3 / 1 9 2 3 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Maryland 1 Ϊ M 2 🗆 F 87 Yrs. 218-14-0365 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State ns 23a or 28a-f show nust be notified at txTYes 2□No Director N/A Baltimore MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21229 1012 Stamford rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. th and Mental Hygiene.
7 is marked other than "natural", or items traumatic event, tre Wedloal Evan natural. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: Black ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) steam ship trade Longshoreman 7th grade 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Catherine Stewart unk Punn ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 7127 Pahls Farm, Pikesville, MD 21208 Karin Lott(granddaughter) item 27 other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or or once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/20/10 Owings Mills, MD Garrison Forest 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 2分份等的Mdreff of Fablirown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 Muamo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf failure. List only one cause on each line. Cardiac Arrest secondary to non— Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day disease or condition resulting in death) /Medical 2 years Due to (or as a consequence of): ischemic Cardiomyopathy Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760. attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 I Inknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 | Yes 2 | No 3 | Probably 4 | Junkhown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 st autonsy nerformed? 1 ∐Yes 2 ☑ No 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manne) of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MEDICAL RESIDENT Dec 10 2010 P25483 PGYI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900s, coton Avenue Baltimore, MD 21229 Priyaa Viswanathan,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 9 2010

ewast, Leon

market

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22 Month Physician/ Sheppard 12:30 A M Junius December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown <u>Seasons Hospice at NW Hospital</u> Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 1 **X**M 2 □ F Hours MD 1072571922 213-12-8864 88 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. Apt. 3I 21212 5220 York Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ★ Yes 2 □ NoArmy Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black If Yes, Give 3 Divorced 4 Divorced Year or Dates. 3.5 years 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Porter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Maggie Willis Junius Shepherd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Apt. 3I Baltimore, MD 21212 5220 York Road Neoma Sheppard / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/28/2010 Woodbine, MD 4 Donation 5 Other (Specify) Final Journey Crematory 22. Name and Address of Facility Maryland Cremation Services Signature of Funeral Service Licenses Marshall Dorota Baltimore, MD 21203 P.O. Box 1413 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final End-Stang (OPD Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transif Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 2 🗌 No 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy funeral director, page 2 performed 7 1 🗌 Yes 2 🗌 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 Yes 2 No after death. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

ny

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ns KyapalineM.D

N.S. Rajupaku, M.D

NFC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29 c. License number

DOUS7465

28355min AV- 5-203, Baltimore, MD. 21209

29d. Date signed (Month, Day, Year)

12/22/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ 6:15P M Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPICE KaltiMore If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Min Director Yrs. 10b. County oermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** BaHiMORE 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, d Forces? Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, . Informant's Name/Relationship(Oype, Print) frieng 20a. Method of Disposition
1 □ Burial 2 ★ Cremation 3 □ Removal from State Donation 21 Signature of Funeral Service 23a. Par J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 🗌 Probably 4 🗌 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 X No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 X Natural 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State Registrar

2010

DECEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Donald December 2010 5:35a Seymour 4b, City, Town, or Location of Death 4c. County of Death Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 Days Hours (Month, Day, Year) April 25. Country) Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2**X**☐ No Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc

Approximate Interval Between

Onset and Death

Day

1 ☐ Yes 2 ☐ No

State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Villa Nursing Home Social Security Number **Funeral** 215-12-2830 **Director** Usual Residence of Decedent or 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director MD 10e. Street and Number Funeral 1700 Summit Ave. Completed by 1 Never Married 2 A Married 1XX Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced WW II Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Supervisor B&O Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elmer Seymour Irma Kensel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. May Seymour (Wife) 1700 Summit Ave., Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place)

Loudon Park Cemetery 12/29/10 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 25. Was case referred to med **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No neral Director: A filled in by the fi Accident Investigation 3 Suicide 4 Homicide 6 Could not be within 24 hours after d

To the Funeral Direct

completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

282010

3455 WILKENS AVE BALTIMORE BASKARAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40881 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** JOSEPH ZACHARY SCHIEFER 05:00 AM 2010 DEC 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Social Security Number 6. Hospita Center Kosedale Daltimore Franklin 8. Date of Birth (Month, Day, Year) MARCH 15,1930 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F 80 220-24-5695 MD Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a live first Examiner must be notified at 1 □Yes 2 No Be Completed by Funeral Director HARFORD FALLSTON MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21047 3427 WIDOWS CARE RD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 | If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 2 🗌 No 3chiefer, Joseph Baltimore, Maryland 21215-0036 WHITE 1 ☐Yes 2 ☐No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "rany Injury or other traumatic event, If a IN 3 any Injury or other traumatic event, If a IN 3 once. Elementary/Secondary (0-12) College (1-4or 5+) GENERAL INSPECTOR CAN COMPANY 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH KAUET 17. Father's Name (First, Middle, Last) CHARLES SCHIEFER ပ 9a. Informant's Name/Relationship (Type. Print)
CHARLES WALDEN, SR.-STEP-SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FALLSTON, MD 21047 3427 WIDOWS CARE RD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition DRUID RIDGE CEM. 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 12/29/10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signafure of Funeral Service Licensee BALTIMORE, MD 21206 6415 BELAIR RD Approximate Interval Between Onset and Death Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Multi-organ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Line University Cause (Disease or injury Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D70605 DEC, 26, 2010 YULING ZHANG, M.D 10x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuling Zhang 31. Date filed (Month, Day, Year) 9000 Franklin Square Drive Baltimore, MD 21237 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

chael Schofie		State of Maryland / Department of Health and Mental Hygiene -For State Registrar Certificate of Death Reg. No.												
Physici edical Exami		Decedent's Name (First, Middl	e,Last) nofield			···		l N	Date of Deat Month	h Day Year		3. Time of Death 1038 hrs		
Sulcai Exami	IIIGI	4a. Facility Name (if not institution		umber)		4b. City, Town, or	r Location of I		ecember	21, 2010 4c. County of				
	Н	Prince George's Hosp		7 Ann (In 1889	leat hidhdoul	Cheverly	ar Killadar (Allen Io	Date of Bird	Prince G				
Funeral Director		5. Social Security Number 220–74–3960	6. Sex		Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.					th(MM/DD/YYYY) /1962	Foreign			
		Usual Residence of Decedent			1 .									
OW Any		MD Prince	e George'		y, Town or Locat	ion Bow	i e					10d. Inside City Limits 1 Yes 2 No		
Aaryland 28a-f show any 1.at once.	Director	10e. Street and Number	George	3		10f. Zip Code			10	og. Citizen of Wha	at Coun			
death with the Maryland or items 23a or 28a-f sho must be notified at once.		15903 Pointer	Ridge Dri	ve		2	20716			United	d St	States		
ath with tems 2.	neral	11. Marital Status 1 X Never Married 2 Married	12. Was De			s Decedent of Hi es, specify Cuba				14. Race - White,		an Indian, Black,		
fter des 17°, or i	y Fu		1 Yes orced If Yes, Give Yes or Dates:	2 X No	1	Yes 2 X No	specify:			te				
hours a natura Exami	Completed by	15. Decedent's Education (Spec	cify only highest gra			it's Usual Occupa ost of working life			done	16b. Kind of Bus	iness/Ir	ndustry		
36 thin 72 ne. than "	nplet	Elementary/Secondary (0-12)	College (1-4 or 5+)		Painte	er			Automob	iles	5		
11215-0036 Id be filed within 72 hours a Aental Hygene. aarked other than "natura" event, the Medical Examin										Maiden Surname)				
	To Be	19a. Informant's Name/Relations			19b. Mailing	Address (Stree				nnowski	, State,	Zip Code)		
re, MD 2 s 1 and 2 shou of Health and N if item 27 is n		19a. Informant's Name/Relationship (Type, Print) Angela Warnick / Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 15903 Pointer Ridge Dr., Bowie, MD 20									071	5		
ore, MI es 1 and 2 s of Health a lf item 27		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal fi	rom State	Place of Dispos crematory or oth tro Cre	ner place)	- 1	Da		20c. Location - 0				
Baltimore, permit. Pages 1 at Department of He Important: If ite Important: If ite Important: If ite Imjury or other tr		4 Donation 5 Other Sp 21. Signature of Funeral Service					Maryland							
Ba Depa Injur		Alakit	C-ATYSU	ni i iay	29	9 Freder	ick Ro	i., B	altim	ore, MD	212	28		
Physician Wedital		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			ne mode of dying	, such as card	liac or res	piratory arre	est, shock, or hear	1	Approximate Interval Between Onset and		
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Gunshot V	Vound of He consequence							-	Death		
-		Sequentially list conditions,	b		-0									
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated	C	a consequence										
ted d ansit		events resulting in death) Last	Due to (or as a	a consequence	of):									
be executed ician and inial - transit	dical	UNPENDED	AMENDED					-						
lox 68760, eath certificate be attending physic for use as the bu	울	IF FEMALE: 23b, Was decedent pregnant in th		outcome of pre		tol dooth 3	Ectopic p	regnancy		23d. Date of d	-	av Year		
Box 68760 e death certificate the attending physical or use as the bu	siciar	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (Specify)									, , , ,			
hed the	Physic	Part II. Other significant conditi	9 01161		resulting in the u	inderlying cause	given in Part I	i. I	23e. Did to	bacco use contrib	ute to t	he cause of death?		
ires that the signed by	و							_	1 Yes	2 🗸 No 3	Proba	ably 4 Unknown		
ords, w requir	plete							_ [24a, Was a autops	sy pr	ior to co	opsy findings available empletion of cause of		
	Completed								perform 1 Yes 2		eath? ✓ Yes	2 No		
ision of Vital Atteoding Physician: r death. rector: After this certifi by the funeral director,	B	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatient		e of Death (Cl			Residence 6	Other:			
n of Vi ding Physi After this funeral dir	5	1 ✓ Yes 2 No 27. Manner of Death	28a. Date		28b. Time of Ir		ury at Work?	28d		ow injury occurred	d			
ision Atteodi r death. rector: ,	atio	Natural 5 Pend 2 Accident Invest	tigation		1800 hrs		Yes 2 V N	°			D	I Day to March 197		
Divis	Certification:		not be	Single Fa	nome, farm, stree mily Home	et, ractory, omice i	building, etc.	- 1	or Town, St			al Route Number, City MD		
Div c Hospital or o 24 hours afte c Funeral Div etely filled in		29a. Certifier (Check only 1 Certifying Ph			e(s) and manner a									
To the within 2 To the complet	Medical	one) 2 Medical Example 29b. Signature and title of certifie	niner:On the basis and manner s		and/or investigat	29c. Licens		Ted at the	time, date a	and place, and du				
		D_M)_				O.C.			i	December 2				
31	1	30. Name and address of person												
		Donna M. Vincenti, MI 31. Date filed (Month Day, Year)		Medical Exa		Penn Street	, Baltimore	e, MD 2	1201					
Si Regist	ate	DEC 282	010 2	was d	back									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 16, 2010 Physician/ 9:40 Ам Dean Κ. Shomper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 8. Date of Birth Ju1y 18. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 1 😿 M 2 🗆 F 1922 Pennsylvania Director 195-14-2772 88 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director the Medical Examiner must be notified 1 🗌 Yes 2 🔀 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 6323 Tone Court 20817 United States items ; permit. Page 1 and 2 should be filed within 72 hours after death \text{Oepartment of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 Black, White, etc Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates:1942-1945 3 ₺ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0wner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည John Shomper Maude Gotschalck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael L. Shomper / Son 979 Redberry Court Great Falls, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 26 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Montgomery Crematorium. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland Inc. 21. Signature of Funeral Service Vicense 22. Name and Address of Facility
Robert A. Pumphrey FuneralHome Bethesda—ChevyChase, Inc.
7557 Wisconsin Avenue Bethesda, Maryland 20814 MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Month shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Respiratory Failure Medical resulting in death) Due to (or as a consequence of Examiner 4 Years Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Litter on tenying Cause (Disease or iinjury Examine Due to (or as a consequence of) Chronic Obstructive Lung Disease attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical il or Attending Physician: The law requires that the death certificate bearinger death.

Director: After this certificate has been signed by the attending physicis in by the funeral director, page 2 should be detached for use as the bur 09289 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopathy, Congestive heart failure 2 No 3 Probably 4 Unknown 1 Tyes Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Prostate Cancer, Hypertension 24a. Was an autopsy performed? Diabetic Melitus 2 X No 25. Was case referred to medical examiner? on of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one)

Q

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Weed War

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Tip Woodward, M.D. 7830 Old Georgetown Road #C15 Bethesda, Maryland 20814

D 17656

29d. Date signed (Month, Day, Year)

12/16/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year A^{M} Eleanor Elizabeth Signora 2010 December 7:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Montgomery Rockville If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Days Hours Director 186-32-1474 68 June Pennsylvania Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director items 23a or 28a-f s her must be notified 1 Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19012 Noble Oak Drive 20874 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give "natural", or item ledical Examiner n 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James McMahon Eleanor Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence F. Signora/Husband 19012 Noble Oak Drive, Germantown, Maryland 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery Crematory or other place)
Crematorium, Inc. December 29 1 Burial 2 X Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Bethesda, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. Charles M01530 300 W. Montgomery Ave., Rockville, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Unsease Crimpury that initiated events that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Pneumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 $\underign M$ Other (Specify) 1 Yes 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA Hospice this the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 (Month, Day, Year) 1 X Natural 5 Pending work? To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completed filled in by the ft. 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Amenda Data Note of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatore and Atle of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201 December 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP, Debrah Miller, 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Roselia Henderson Slingluff 2010 P^{M} December 1:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15404 Wentbridge Court <u>Silver Spring</u> Montgomery 8. Date of Birth (Month, Day, Year) April 30, 1933 If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Days Hours 1 M 2 X F 579-40-1993 Yrs. Director 77 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location death with the Maryland 10d, Inside City Limits Director 28a-f 1 Yes 2 X No Montgomery Maryland Silver Spring 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 23a 15404 Wentbridge Court 20906 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 ANo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or any injury or other traumatic event the Marier. à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hayward Henderson Margie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. Slingluff/Husband 15404 Wentbridge Court, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 23 Montgomery -1
Burial 2 X Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Crematorium. Bethesda, Maryland Inc 21. Signature of Funeral Sept Light ee Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Ave., Rockville, MD 20850 Mai 4 augu 71. M01530 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Metastatic Breast Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo 5 Other (specify) Month Day Year Pregnant at time of death ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Renal Failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records. Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 **X**No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 No neral Director: A filled in by the fi Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d, Date signed (Month, Day, Year) D35703 December 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

10V

Slipalof

6240 Monstrose Road, Rockville, Maryland 20852

M.D.,

32. Registrar's Signature

Stephen Vaccarezza,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Mamie Schultz 2010 Dec. 11:53 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) April 20 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 7 F Days Country) 97 Director Yrs. 216-01-9633 191 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkton MD Baltimore 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18667 Middletown Rd. 21120 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 😾 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white 3 X Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 6 n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Sykes Edward Devlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z. $18667\ Middletown\ Rd.,\ Parkton,\ MD\ 21120$ Doris C. Haga/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/10 Oaklawn Cemetery Baltimore, MD 21. Signature of Funeral Socio Lice, res Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MONT Medical Due o (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 DECEMBER 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? page 2 should be detached for Month Day Year Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. signed 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? SCHULTZperforme Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: ျှ 2 17 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) MARGARET Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Funeral Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 | Certifying Nurse Practioner; To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie CONOS 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 ERNESTINE WRIGHT, M.D.31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 710

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

field

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G911 1/10/2011 H State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Olga M. Schultheis 2010 December 10:40a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sykesville Fairhaven If Under 1 Year | If Under 24 Hrs. \$217-76-5596 7. Age (In vrs. last birthdav) 8 Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 ⋤ F 95 Yrs. Director Feb 1915 NJUsual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Funeral Director MD Sykesville or 28a-f Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Aspen 104 21784 USA 7200 Third Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0. Completed by 1 Never Married 2 XMarried 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: white 3 🗆 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) school teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Grimm Joseph Hagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave., Aspen 104, Sykesville, MD 21784 Department of Health ar Important: If item 27 is any injury or other tratonce, Lester W. Schultheis (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 12-27-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Haight Sterbert Sykesville, MD 21784 P.O. Box 195 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ons ostive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 1 Natural 28d. Describe how injury occurred injury 5 Pending ours after death.

neral Director: Aff Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 34849 December 27 2010 dress of person who completed cause of death (Item 23a) (Type, Print) MD 1645 Ja 31. Date filed (Month, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ DECEMBER 22, 2010 \mathbf{A}^{M} THOMPSON 12:35 DOROTHY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NORTHPOINT <u>FUTURECARE</u> <u>DUNDALK</u> If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) Months JUNE 1 1 M 2 XF Days Hours Min. 84 Director 579-34-0183 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 3a or 28a-f sh 1 X Yes 2 No MD BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral PENINSULA EXPRESSWAY APT USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【★No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed Specify: 3 X Widowed 4 Divorced BLACK Year or Dates other than "natu vent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mental Hygiene. LPN HEALTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Fitem 27 is marked o ည JOHN FULMORE MARY E. GRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr BETTY STEINER/SISTER MANSFIELD. MARYLOU CT. TEXAS <u> 76063</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1-4-2011 OWINGS MILLS, MD GARRISON FOREST VET. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS SF.H., INC. <u> 1701–31 LAURENS ST.</u> BALTIMORE, MD 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart fallure. List only one cause on each line. Immediate Cause (Final Ph sician/ Cancer etastat INKHOW Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in tisted as or the cause (Disease or th Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? page 2 should be detached for Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 2 No Yes Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 2 No 1 Tyes Accident Investigation Could not be 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salaz 36 dr Z

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State

Registrar

Year)

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31, Date filed (Month

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			1. Decedent's Name (First,	Middle, Las	st)							2. Date of Dea	ath			3. Time of Death
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	Examir		4a. Facility Name (if not ins		street and numb	er)		4b. City,	lown, or	Location o	f Death		4c	. County of De	ath	
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	Funeral	12	5. Social Security Number 243-20-422	6. 8	ex 7	. Age (In yrs. la 88		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Day		9. [Birthplac	ce (State or Foreign
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	arylar a-f sl fied	Director	MD. H	SALTIM	ORE		CATONS								1 XYes 2 ☐ No	
	he Maryland or 28a-f show e notified at	ä	10e. Street and Number					10f. Zip					10a Ci	itizen of What	Country	?
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	ems r mu	ığ	6000 MIDVA	LLE KD	12. Was Decede	ent Ever in U.S		as Decede	ent of His	spanic Orig	in? (Spe	cify Yes or No-		USA 14. Race - Ar	nerican	Indian,
ပ္	er de or it	by F	1 Never Married 2	Married	Armed Force 1 Yes 2 If Yes, Give	es? 2 J vNo	lf lf	Yes, speci	fy Cubar	n, Mexican	, Puerto I	Rican, etc.)		Black, W		
8	rs aft Iral", Exa	ed	3 🛚 Widowed 4 🗆 D	vorced	If Yes, Give Year or Date	es.	1	☐ Yes 2	XV0	Specify:				Specify:	LAC	K
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed		ecedent's E	ducation ade completed)		16a. Deced	ent's Usua	Occupa	tion	of working	22		(ind of Busine		stry
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2	with ygien her ti				-0-		NUR	SE					51	CATE HO	SPI	TAL
pu	filectal H	To Be	17. Father's Name (First, M	iddle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Surname)		
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altimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispositio 1 🔀 Burial 2 🔲 Çel	nation 3	Removal from S	tate 20b. P	Place of Dispos emetery, crem) 12	2-28	2010	20c. L	ocation - City	or Town	, State
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P.O.	that the ped bedeta	y P	Part II. Other significant o	onditions o	ontributing to dea	th but not res	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to	obacco i	use contribute	to the c	cause of death?
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チップサ Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as to complete the funeral director, page 2.	Certificate: 1		Pending Investigation	28a. Date of (Month,		28b. Time of injury		c. Injury work?	at	2	28d. Describe h			oony)	
isio	Attendi		3 Suicide 6 🗆	Could not b	e 28e, Place o	f Injury - At ho	me, farm, stre			.00	_	28f. Location (S			Rural Ro	oute Number,
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	To the		29b. Signature and title of	certifier (ole	MI	D	29c.	License	number 63	54		29d. Da	ate signed (Mo	nth, Day	(, Year)
	6		30. Name and address of p	erson who	completed cause	of death (Item	23a) (Type, P	rint)					1 500	1		
				CE :	STAGN	Strar's Signat	900	CATO	SN	AVE	B	ALTIA	nok	RE V	(D)	21229
	Sta Registra	e	n. Date med promin, Day,	C 28	2010 ×2	noural o olyriat	A. 4	barke	A. C. C. C. C. C. C. C. C. C. C. C. C. C.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. 2010 Alice Taylor 12:45A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fayette Health & Rehab. Ctn. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X** F (Month, Day, Year, 3 - 0.1 - 6.1 Country) 085-54-4387 49 NY Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4711 Sayer Avenue Apt."C" 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, et African Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: American 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Dental Assistant <u>12th</u> Grade NABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Staling Emmitt Annie Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11691Annie Taylor-Mother 344 Beach 44th Street Queens, New York Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 12-28-10 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 Ν. Street Baltimore, MD 21217 Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastas Conon multale Physician Inal disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it can be used to be cause. Enter Underlying Cause (Disease or iinjury Examiner Due to jor as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b , page 2 sl autopsy performe After this certificate by funeral director, page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours are. _____ To the Funeral Director: After this c 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 031885 nin-p 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cutan of Bast more md 821 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Year 7:30gm Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death L'Ulicott 68 Reh Citz, MILLIVEDTT Crtu Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
Apr 1, 1927 Piorto Pico 581-28-9366 Director 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD Howard Elkridge 1 - Yes 2 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5981 Avalon Dr. 21075 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes, Give marked other than "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natum any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Television & Radio Announcer **Broadcasting** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Federico Torres Mercedes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miguel A. Torres, son 5981 Avalon Dr. Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Dec 27, 2010 Atlantic Crematory, LLC Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Inter the discress or complications that decide the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failum. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ panger disease or condition resulting in death) Medical Examiner vase ular distall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine and I-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed Yes 2 **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 No ٥ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

25 V

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

3100

N. Midge

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ad.

Bilizott City mD 21043

10-09507	
Aquilla Mae	Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death dent's Name (First, Middle Last) Time of Death Physician/ 1934 hrs December 10, 2010 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 2601 Madison Avenue, Apt. 103 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreian Months Days Hours Min Director Country) M Usual Residence of Decedent 10d. Inside City Limits 10a State 10b Count 10c City Town or Location Yes 2 No hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e Street and Numbe 238 Funeral 14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 Yes Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 h ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "r or other traumatic event, the Medical E Baltimore. MD 21215-0036 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surna Be 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery 20c. Location 20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify Signature of Funeral Service Licenses FUNEVA Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and (Modern) Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical AMENDED 23a,pt.II,27 per me g911 1-20-11 vt X UNPENDED attending physician or use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760. IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy dent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Cocaine Use Completed 24a Was an 24b. Were autopsy findings available has been prior to completion of cause of autopsy death? performed ✓ Yes 2 No 1 Yes certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other Scene ER/Outpatient 3 DOA After this c 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending Director: d in by the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 11, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)
DEC 28 2010

DHMH 17 Rev 1/2001 OCME 2006

State Registra

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Georgia Regina Thorn December 5:20 P.M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Manchester Carroll 4711 Water Tank Road Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Y Feb. 22, Days Hours 1 □ M 2XXF Months Min. Country) Maryland 87 **Director** 218-12-7943 Usual Residence of Decedent f show 10a. State 10b. Count filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Carroll Manchester 10e. Street and Number 10g. Citizen of What Country? United States of America 10f. Zip Code Funeral 4711 Water Tank Road 21102 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes XX No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. Yes XX No Specify: Completed 3 Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 9th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot Nicholas Stolzenbach Edith Meushaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geargia Regina Devese (Daughter) 2500 Foxtail Court, Hampstead, Maryland 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec Date 29 any injury or c XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ other (Specify) permit. Page Department o Important: If Lineboro Cemetery 2010 Lineboro, Maryland Stignature of Fulle at 5-1 ice Lice. 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 t 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ ancreatie disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions il any, leading to immedicause. Enter Underlying Dun to for as a consecuence on Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and defeated for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Known Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed?

Yes 2 No is certificate h death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 XNo Other: ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. 28h Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 \square Pending Accident 1 Tes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State 24 hours Funeral Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 12/27/10

State Registrar

DHMH 17 Rev 7/2009

S. Center

Street

Westminster Md. 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Sais. + z M. D. 555 S. Ce

31. Date filed (Month, Day, Year)

10-09378 Joe Louis Tasker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	5. 50	cial Security N	^{vumber} unk	1 XM		7. Age (III y	7(Months Dave Hours Min							1940		ntry)	unk
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e, MD I and 2 sho Health and Item 27 is		O.C.M.E Method of Dis				2		e of Disposi	tion (Name o				more,	_	2120 : Location -		Town, State	<u>. </u>
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). Box 68760, the death certificate by the attending physic order for use as the burner Physician/Med	6 1 T	east 12 month		4	Pregn	ant at time	of death		ner (Specify)			F11-9					,	
D. Bc	Part	II. Other sign					not result	ing in the u	nderlying ca	use giv	ven in Pa	rt I.	23e. Did	tobacc	o use contri	bute to t	he cause of	f death?
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that t is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach the fine and the Commission of the second of the contribution. To Re Commission by the funeral director, page 2 should be detached by the funeral director.		lanner of Dea	ith		28a. Date (Month	of Injury , Day,Year)	28t	o. Time of Ir			at Work	- 1	28d. Describe	e how in	njury occurre	edi		
Sion Attendideath. Sector:		Matural Accident		ding estigation	28e Place	e of Injury -	At home	farm stree	t, factory, of		es 2		28f. Location	(Street	and Number	er or Rui	al Route N	umber, City
Division o Hospital or Attending 4 hours after death. Funeral Director: After lely filled in by the fune	3 4	Suicide Homicide		ld not be ermined	(Specify)	e or injury	, a nome,	, idim, ou oc	х, тавсоту, в		manig, a		or Town,					
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certification is after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as wedical Certification: To Be Completed by Physician		Certifier 1 2	Certifying F	hysiclan:	To the bes	st of my kno of examinat	wledge, o	death occur or investigat	red at the tim	ne, dat inion,	e and pla death oc	ace, and co	lue to the ca	us e (s) a e and p	and manner place, and di	as state	d. e cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Lillie Vanlandingham Month Physician/ 1:15 F M Deamber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Seasons Hospice Baltimore Battimire If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Maryland 225-16-0441 Jun Director Usual Residence of Decedent or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f shor Examiner must be notified at Director 1 Yes 2 No MD Battimore Mills Windsor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 7906 Dun Hill Village Circle#20 21244 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black If Yes, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Department Store Elementary/Seconday (0-12) College (1-4 or 5+) Clerk etail other traumatic event. Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Wright Willie Beatrice Jones 19a. Informant's Name/Relationship (Type, rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7906 Dunited Villiage Circle \$01, Batto MD 21244 Nellie Wright 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
MT. Zion Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec 29,2010 Catonsville 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Livensee Name and Address of Face 1/ Uton Pass Funeral Service Baeto, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Rectal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events after death.

Director. After this certificate has been signed by the attending physician and I in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other Specify Worker 1 ☐ Yes 2 ☐ No Other: မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗖 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ns Rajupahre M.D 12/22/10 D0057 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 SMAN N- 5-203, Baltimore, MD. 21209 N.S. Rajupakse MIO 31. Date filed (Month, Day, Year, DEC 28 2010 parked Registrar

ORIGINAL

DHMH 17 Rev 7/2009

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lanc	ild be i lental l iked o	To Be	Antonio Alfred	lo Velasco \mathcal{E}	ienfuego ienfurgo	s S			Irven	Hermoza	A Corazao A 22556 20c. Location - City or Town, State Woodbine, MD Cremation Services e, MD 21203									
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	and and health		Nadia Saba Vel	asco			Pike Pi		e Staff	fford, VA 22556 Date 20c. Location - City or Town, State										
nor	Pages nent of I int; If ite iry or o		1 Durial 2 Cremation 4 Donation 5 Other (S		Final	ry, cren	rnev C	r place		2/27/10	Wo	odhine	MD							
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8	S = E S		232 Paril 1 Enter the disease of	-Homen	d the death Do	not enti	P.O. B					D 21203	Approximate							
y.	hysician /Medical		23a. Part 1 Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each I					ntrast		n _		Interval Between Onset and Death							
			disease or condition resulting in death)	a. Due to (or a	s a consequence	of):					1									
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	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence	70															
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68760	ificate be executed g physician and as the burial-transit	dica		d							1	8-								
Box	ding	d by Physician/Medical	ıysician/M	nysician/M	nysician/M	ysician/M	ıysician/Me	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death		Ectopic preg Other (speci	ctopic pregnancy her (specify)					23d. Date of delivery Month Day Year	
ds, P.O.	w requires that the been signed by a should be detact		Part II. Other significant conditi	ions contributing to death	but not resulting	in the u	ınderlying cau	use giv	ven in Part I.				to the cause of death?							
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ital		Be C	25. Was case referred to medica examiner?	al .					26. Place of Dea											
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Division of Vital	ng ther	Certification:	27. Manner of Death 1 □ Natural 5 □ Pendi 2 ☑ Accident invest 3 □ Suicide 6 □ Could	ng (Month, D) igation 12/16/	2010 1:	Injury 3/2	М	Work 1 □ `		Unch	ear	mechan	Rural Route Number,							
Ω̈́	l or At after d Direct	ertif	4 Homicide determined building, etc. (Specify)				treet, factory, office 28f. Location City or To					(e)	more MD 21287							
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	Medical C	29a. Certifier 1 Certifyi (check only one) 2 Medica	ing Physician: To the besil Examiner: On the basis and manner	of examination a	e, death nd/or in	occurred at vestigation, in	the tin	ne, date and plac pinion, death occ	e, and due to the	he cause ne, date a	(s) and manner	as stated.							
29b. Signature and title of certifier									4.0		ate signed (Mor									
					death in an		Deint's	K	E5-0	00	Dec	cember	20, 2010							
	150		30. Name and address of person	Akbari) (Type,	rrint)		600	North W	olfe :	St, Baltim	ore, MD, 21287							
	Sta	ite	31. Date filed (Month, Day, Year)	9 2010 32, Reg	rar's Signature	6	1	,	-											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 11:12 Ruth A. Vaccacio Dec 23 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Carroll Hospital Center Westminster Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Funeral Days Hours NY March 24 1924 Director 099-16-2418 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the medical Experience must be refulled at 1 ☐ Yes 21 No Director MD Carrol1 Eldersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 USA 1073 King Arthur Ct. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 USA 1 □Yes 2 No Specify. Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Krueger Minnie Tiejen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar permit. Pages 1 and 3 Department of Health Important; If item 27 any injury or other tra 1073 King Arthur Ct., Eldersburg, MD 21784 John P. Vaccacio/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12/27/10 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Signature of Fluneral Service Licenses & Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Imonay disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) ed by the a cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed r Attending Physician: The certificate 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 IMo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Division of Vital Records, 24 hours a er death. To the Hospital or Atter within 24 hours all er ded To the Funeral Director completely filled in by th

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause

and manner stated.

24 Washington Hights Medical Center, Westminster, mi)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ MALA 9.10AM NILLIAMS 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice <u>Baltimore</u> 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1X M 2 □ F Months Days Hours 05/18/1940 PA Country) 218-36-7841 70 **Director** Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5713 Penbroke Ave. 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 Mo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education Balto. City Public (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) School System 5+ Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Williams Lillian Smith 19a. Informant's Name/Relationship (Type, Print) (daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5713 Pembroke Ave., Baltimore, MD 21207 Tonya Williams Thomas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Mem. Park 01/06/10 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANCER WITH LIVER ANCREATIL Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ Month Pregnant at time of death 9 Unknown certificate has been signed by the infector, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? INPATIENT Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventigation in my policy Medical 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractionar To the best of my knowledge, death oncurs at the time, date and place, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TACHEDM (AICHAN). 2835 SmiTH AVE, BACTO

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 6:25 PM Abife Wallace Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Baltimore washington medical 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Marry)land **Funeral** 8. Date of Birth 1 □ M 2X□ F Days 0/90/10/24/191918 92 Yrs Director 214-38-8556 Usual Residence of Decedent 10a. State 10b. County death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Anne Arundel Brooklyn Park MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 6017 Ritchie Hwy 21225 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after al Hygiene. 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify Specify:Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 8th Grade Domestic Engineer Ith and Mental Hygier 27 is marked other to traumatic event, the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Josiah Wallace Olive Brooks Page 1 and 2 should be ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Marva Gaither(Niece) P.O.Box 344, Severn, MD 21144 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Calvery 4 ☐ Donation 5 ☐ Other (Specify) 12/23/10 Baltimore, MD 21. Signature of Funeral Service Licenses Joseph H. Fulton Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on quich line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ renmom disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗌 No Yes 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes 잍 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Vatural 2 Accident 5 Pending injury s after death, I Director: Af 1 Yes 2 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Signature and title of certifie 2010 person who completed cause of death (Item 23a) (Type, Rrint)

Registrar
DHMH 17 Rev 7/2009

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nth, Day, Yeār

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20ay White 2010 Elizabeth 4:00p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Frederick Villa Nursing Home Catonsville 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2🗓 F Hours Min. Country) 96 Director 215-14-8957 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Catonsville 1 Yes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21228 U.S.A. <u> 1044 Lakemont Road</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married "natural", or Completed by 72 hours after ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give 3X☐ Widowed 4 ☐ Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry
Franklin Square (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Hospital 4th grade na Nurse Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Mattie Dixon Tom Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1044 Lakemont Road, Catonsville, Md 21228 <u> Victoria Jones-Daughter</u> injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Woodlawn 12/23/2010 Woodlawn, Md 21. Signature of uneral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, MOD Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Cardionswar Onset and Death Immediate Cause (Final Physician/ Athenosclerotic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Dementia-Vasular death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 7. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending iniury after death. I Director: Aft 1 Yes 2 No Accident Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Pd Str 205 Catensuil 5/6

DHMH 17 Rev 7/2009

State Registrar

Box 68760

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Division of Vital

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#9, 15-18perFH, G911, 1/14/2011, WS.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 2010 8:36 a^M Kevin L. Wilson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 1

↑ M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Yea, Director MD 214-90-0963 46 Ĩ964 Usual Residence of Decedent Department of Health and Mental Hygiene. Important If item 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director UK № 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. UK Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ₩X≪Security Guard 10 Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Wilson Eddieruth Finch unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Wilson / Niece 2876 Mayfield Ave Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 12/27/2010 4 Donation 5 Other (Specify) Journey Crematory Woodbine, MD Significant Service License 22. Name and Address of Facility Maryland Cremation Services Baltimore, MD 21203 P.0 Box 1413 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ACQUIRED IMMUNE DEFICIENCY SYNDROME Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any leading to immedicause. Enter Underlying Due to for as a consequence of Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) **HOSPICE** ျ 1 ☐ Yes 2 👿 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 | No Investigation Accident 24 hours after deat Funeral Director; 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

DECEMBER 23,

ORIGINAL

2300 DULANEY VALLEY RD.

32. Registrar's Signature

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Gail Toby Williams 12:30a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours 0, Day, Year) 04 1936 220-32-8986 **Director** MD 10 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 1 Eastern Blvd U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Retail æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Foote George Thomas Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River, MD 21220 Son Cunning Ct Bret Steven Dickerson DECEMBER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State Final Journey Crematory 4 Donation 5 Other (Specify) 12/28/2010 Woodbine, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death RATIO Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death the g Unknown g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy I Director: After this certificate has d in by the funeral director, page 2 s perform 2 🗌 No Yes 2X No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ျှ 1 Tes 2 **X** No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending 2 🗌 No Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours a 24 hours Funeral Medical 29a. Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and atle of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State

DHMH 17 Rev 7/2009

Registrar

WILLIAMS

GAIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Physician/ Month Medical Town, or Location of Death Eacility Name (if not institu ion, give street and number 4c. County of Death Examiner nKINS KaHIMOTE John Ho 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be actived once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 XYes 2 □ No 10f. Zin Code 10e. Street and Numb 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10ma aintenance Be ၉ Sm 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, 20c Burial 2 Cremation 3 Removal from State Donation 5 Cher (Specify) 21. Signature of Funeral vice Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shyck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Atheroscleratio Cardiovascular disease or condition resulting in death) Medical Examiner HYPERTENSION if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No as been signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERUPIDEMIA 2 No 3 Probably 4 Unknown CHRONIC DISEAJE 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PROSTATE CANCER certificate has autopsy performed? page GEUT 2 🗌 No 1 Yes 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work 5 Pending Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D28987 12-23-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO, MD. SERLING 5601 RAVEN BLW LOCH 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

•			- For State	Cer	tificate of D	eath		Re	g. No.	
Р	Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day							3. Time of Death		
	Éxami		Rodney Wade Williams, Sr. Month Day Year December 18, 2010							0514 hrs
			4a. Facility Name (if not institution, given	e street and number)	4b. (• • • • • • • • • • • • • • • • • • • •	ocation of Dea	th	4c. County of Dea	ath
			Johns Hopkins Bayview Medical Center Baltimore							
Fu	uneral	T	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY)							Birthplace (State or eign Country) MD
Di	rector		217-04-8559	I MODIOS I DAVS I HOUES I WILL I						
Usual Residence of Decedent										
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aryla	or items 23a or 28a-f show must be notified at once.	섫	10e. Street and Number		10	of, Zip Code		10	g. Citizen of What Co	ountry?
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with	1s 23;	<u> </u>	11. Marital Status	12. Was Decedent Ever in U.				Specify Yes or No-	14. Race - Am White, etc	erican Indian, Black,
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21215-0036 Puld be filed within 7	rrked vent,	B	Wesley Will		Lan Mari	10		a Lewis	ber, City or Town, St	ato Zin Codo)
D 21215-0036 should be filed within 72 hours after death with the Maryland	is m	우	19a. Informant's Name/Relationship (Laikiesha Wils	on Williams) 19b. Mailing At					
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	sician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused the reath ach line.	. Do not enter the r	node or dying,	such as cardiac	or respiratory arre	est, shook, of fleat	Between Onset and Death
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			or condition resulting in death)	Due to (or as a consequence of	f):					
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	Withii To the comp	Medical		and manner stated.		29c. Licens			29d. Date signed	
		≥	29b. Signature and title of certifier			O.C.			December 19	
			his his			0.0.				
·nX			30. Name and address of person wh		^{n 23a)} 1 Penn Street,	Raltimore	MD 21201			
101					-					
	S	tate	31. Date filed (Month, Day, Year)	32. Fegistrar's Signal	d Day	les .				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Kalherine 10.10 PM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL N/A BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) JULY 16,1932 MARYLAND **Director** 217-26-8847 78 Usual Residence of Decedent show 10a. State 10c. City. Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1XXYes 2 No BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5717 NEWHOLME AVENUE 21206 U.S.A. ould be filed within 72 hours after death v id Mental Hygiene. marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent 2... Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 X Married ρ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GRADE HEAD TELLER BANK permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **APOSTOLEDES** GLADYS NORRIS MICHAEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCIS WEBER/HUSBAND 5717 NEWHOLME AVENUE BALTIMORE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/24/2010 GARDENS OF FAITH CEM. BALTIMORE MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MILLER-DIPPEL FUNERAL HOME, INC.
6415 BELAIR ROAD BALTIMORE MD 21. Signature of Funeral Service License 212<u>06</u> 23a. Part 1. Enter the dia or complications that the complete the complete the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or hea List only one cause on each line. Onset and Death Physician/ disease or condition resulting in death) Medical Due to (d as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last certificate be executed ierue and Due to (or as a consequence of) physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months? Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Yes Fuspital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifications. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed Month, Day, Yearl S Dil Currel 23 29c. License number 6 1 29b. Signature and title 2010 30. Name/and address of person who completed cause of death (Item 23a) Type, Print) 100

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WHITE IR. 0855 CARL 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE, MARY LAND UNIVERSITY OF MARYLAND MEDICAL CENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral 1 X M 2 □ F Days Country) 2/26/1942 MD Director 217-38-7908 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Joppa 1 ☐ Yes 2 🖺 No Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21085 1000 Beall 12. Was Decedent Ever in U.S Armed Forces? 106 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1962-Black White etc. 1 Never Married 2 Married Completed by Yes 2 ☐ No Yes, Give Specify: White Baltimore, Maryland 21215-0036 1965 1 ☐ Yes 2 X No Specify. 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Computer <u>Manager of Support Services</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည May E. Birkett Carl H. White, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Beall Dr., Joppa, MD 21085 Sandra White / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 12/27/2010 Hanover, MD Ardent Cremation 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family Fit, Inc. M01411 21. Signature of Funeral 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEMORKHAGIC STROKE disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner 10 hours ISCHEMIC STROKE Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours. (Iter death.

To the Funeral Infector. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the hindelform. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Veal 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by INFARCTION MYOCARDIAL 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ours fiter death.

eral Director. After this certificate has I autopsy death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: 힏 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 1568787927 12/26/2010

State Registrar 22. S. GREENE ST, BALTIMBRE, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SARAH B. DUBBS, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cherie Wein 2010 12:30 AM Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5019 Waterloo Rd. Ellicott City Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 429-88-2591 1 □ M 2 🛛 F Months Min. 4/97/1946 64 **Director** Arkansas Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Howard 1 Tes 2 No Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5019 Waterloo Rd. 21043 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Professor Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Newton Seitzinger Claudia Kilgore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5019 Waterloo Rd. Ellicott City, MD 2104 19a. Informant's Name/Relationship (Type, Print)

Ira Wein - Husband Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State st. John's Luth. Cem. 12/29/2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
2009 - proscuri shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Vourcendo disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 🗶 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2ga Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D0 05 7 256 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Arenue, Bultmore, Mary land 21215 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 12:30 PM Willson Walter K. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 2208 Lake Avenue 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Maryland 05-27-1948 Months Days Hours Min. 1 X M 2 D F 62 Director 213-54-4571 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland N/A Baltimore 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21213 USA 2208 Lake Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black White etc. 1 Never Married 2 Married Completed by Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospitality Bar Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter M. Willson Catherine Yungmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Lake Avenue <u>Baltimore, Maryland 21213</u> <u> Sylvia Willson - Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 12-30-2010 Baltimore, Maryland 5305 Harford Road 21. Signature of Funeral Service License 22. Name and Address of Facility Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that c used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death PleoMORPHIC SarcomA High Grade Undifferentiated Physician/ disease or condition resulting in death) Medical Du ato (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjur) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe eral Director; After this certificate filled in by the funeral director, pag 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Tes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D61769

State Registrar 401 NORTH

BROADWAY, BALTIMORE, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTIAN FREDERICK

31. Date filed (Month, Day, Year)

MEYER

MD

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/20/2010 Grace Yalich 11:07an Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center BelAir Harford 1 Year If Under 24 Hrs Days Hours Min. 7. Age (In yrs. last birthday) if I Inde 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 189-22-5148 1 □ M 245XF Months Director 82 5/22/1928 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Miportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Kingsville 1 ☐ Yes 2XXNo 10f. Zip Code 21087 10e. Street and Number 10g. Citizen of What Country? 18 Wildon Court Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify Specify: White XX Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beauty 12 Hair Dresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mildres E. Means ပ Ε. Conroy Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Wildon Court, Kingsville MD 21087 Yalich Larry Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Hanover MD 12/30/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home asi 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conseque Cause (Disease or iinjury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death the 9 Unknown ed by t been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s performed 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 PHO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 0056607 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person where PLUMTREE RJ. BEL ARR ANGELO

Registrar
DHMH 17 Rev 7/2009

State

8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G913, 3/1/2011 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Medical ana 2010 December 10:35 P M 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 7421 Helmsdale Road Bethesda Montgomery 054-72-8886 **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🕅 F 9. Birthplace (State or Foreign Director Days August 25 Yrs Hours Min. 50 China 1960 Usual Residence of Deceder "natural", or items 23a or 28a-f show edical Examiner must be notified at should be filed within 72 hours after death with the Maryland 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Bethesda 1 Tes 2 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 7421 Helmsdale Road 20817 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. 3 Divorced Completed 1 ☐ Yes 2 🛣 No Specify: Year or Dates Specify: Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Qing Dao Yang injury or other traumatic Su Fang Wei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>Willie M. Yu</u> / Husband 7421 Helmsdale Road, Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1

Removal from State

1

Donation 5 □ Other (Specify) December 20c. Location - City or Town, State 27, Parklawn Memorial Park 2010 Rockville, Maryland 21. Signature of Funeral Service Licensee Robert A. Fumphrey runeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Q M01596 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events. Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) -burial-Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? for 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certificate: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) eral Director: After filled in by the funer 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending injury work 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical within 24 hor To the Fune completed fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year) D37142 12-23-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Piccourd G. Coleman 1355 Rockville 20850 31. Date filed (Month, Day, Year)
NEC 28 2010 State 32. Registrary Signature DEC 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Earl Elwood Yingling 11:40 P.^M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Longview Nursing Home Manchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 8, 192 9. Birthplace (State or Foreign Social Security Number 6. Sex 1. M 2 ☐ F 7. Age (In yrs. Jast birthday) **Funeral** Country) Maryland 89 **Director** 218-10-9455 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2XXNo Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America "natural", or items 23a o Funeral 21074 4148 Sellman Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status Armed Forces? 1A Yes 2 □ No WWII Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Manufacturing Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Truck Bodies 9th Truck Body Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve ည Harvey C. Yingling Lilly Armacost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 Amalfi Drive, Westminster, Maryland 21157 Eugene Yingling (Son) Dec. 30, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) New Lutheran Cemetery Manchester, Maryland Dignature of Fundral Strylice Licens 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ck, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ cemio disease or condition resulting in death) Medical Due to (as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and I-trans Due to (or as a consequence of): resulting in death) Last by the attending physician a stached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. if yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be detent δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed VPEcertificate abetes 1 Yes 2 No Yes 2 filled in by the funeral director, Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this or 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending 1 Yes Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), over-Beckleysville R Date filed Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Physician/ 2010 7:50 Margaret D. Zabawa November Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Winter Grove Assisted Living 01ney Montgomery Birthplace (State or Foreign Country)
 Toward 8. Date of Birth
July 22, 1918 Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours Months 1 M 2 X F Towa 387-16-1693 92 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2x No MD Montgomery 01ney 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20832 18110 Prince Philip Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) teacher education Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Melborne Donhowe Charlotte Marvich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 323 Indian Trail Afton, MN 55001 Charlotte Zabawa/daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify) State Andromy Board 655 W. Baltimore Street Signature of Euneral Service 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscleroscs ycers oronan disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Uncertying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed use as the burial-transit cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Debelity 24b. Were autopsy findings available prior to completion of cause of Facture to Thrive 24a Was an autopsy performed After this certificate has death? 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-16-201 37147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville WLD 2085 1355 Piccerd Sink 100 DY Coleman 82. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 28

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 9:07 A.M December Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟፟ M 2 □ F Months Days Hours Min. (Month, Day, Year) Country)
Maryland Director 212-30-5619 76 Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No Maryland Harford Whiteford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1828 Delp Road 21160 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-003 If Yes, Give Specify: White Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Freight Hauler Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rocco Alimo Josephine Edith Alascio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent Alimo 100 Griffith Road; Delta, PA 17314 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) orraine Park Cem. 12/31/2010 Woodlawn, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Juneral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) Examiner ears Sease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE fyes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 9 Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 No ER/Outpatient 3 DOA 1 Inpatient 2 N funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending filled in by the Accident Investigation ☐ Accider
 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2. only one) 3 29b. Signature and title 29d. Date signed (Month, Dav. Year) 3 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 500 UPPER CHESAPEAUE DRIVE BEL AIR MD 21014 JORDAN M.D. 31. Date filed (Month, Day, Year) State 29 Registrar

DHMH 17 Rev 7/2009

0107

State of Maryland / Department of Health and Mental Hygiene [] [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec-ember 06:16 JOHNNIE D. ANDERSON Medical DOIO 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Baltimore Singi Hospital Baltimore If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. Month, Day, You JULY 20 1 🛛 🔀 1 2 🗆 F NORTH CAROLINA 89 Director 921 243-01-5810 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 No BALTIMORE MARYLAND N/A 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3703 KINGWOOD SQUARE dohnnie 21215 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married "natural", or 21215-0036 If Yes, Give Year or Dates. 45/45 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade CONSTRUCTION BRICKMAKER Be Maryland 17. Father's Name (First, Middle, Last) Known 18. Mother's Name (First, Middle, Maiden Surname) ၉ WILLIE ANDERSON ZELMAR DAUGHTRIDGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra <u>Christine M. Weambe/Daughter</u> 3703 Kingwood Square, Baltimore, Maryland 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Domation 5 Other (Specify) GARRISON FOREST 01-05-11 OWINGS MILLS, MARYLAND re of Fundal Service Ligense 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. MIL art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Sebsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular accident 1 Yes 2 No 3 Probably 4 Unknown been Mybertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has the page 2 performed? 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) Hospital: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MBBS December, 26, 2010 RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore KAPOOR, MBBS 1 Sina Mosbital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 29 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMIN December 7 2010 1926 DM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical Center of Maryland Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Country) India Director Yrs. 037-52-1412 75 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD 1 🗆 Yes 2 💢 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1005 Havencrest Street 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Year or Dates Asian Indian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Assembly Worker Mechanical Assembly permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumation. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Dhayabhai Amin</u> Lalitaben Amin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jayesh Amin / 1005 Havencrest Street Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 12-30-2010 <u>Odenton, Maryland</u> 21. Signature of Funeral Septice License 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Annapolis Road Odenton, Maryland 21113 a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock Physician/ disease or condition resulting in death) Medical Due to (or as consequence of): **Examiner** one week EMI Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No 2 1 No 1 Tyes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗖 No Other: 1

✓ Inpatient 2

ER/Outpatient 3

DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 only one) 29b. Signature and title of certifier 29c. License number Resident Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sin BALTIMORE John 22 S. GREENE 51 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b, perFH, G910, 12/29/2010, WS
State of Maryland Department of Health and Mental Hygiene | For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** Q:OZAM oretta 2010 ecember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 6, 1950 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** VÃ 212-92-9434 60 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County 28a-f shov 1 Yes 2 □ No traumatic event, the Medical Examiner must be notified at 21205 Director MD Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö 21205 927 N. USA Luzerne Ave. 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 9th Soo <u>Chef</u> Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Brown Mary Redd 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: 9 Department of Health an Important: If item 27 Is any injury or other trau once, Wesley F. Aydlett (husband) 927 N. Luzerne Ave. Balto, Md. 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. 6, 2011 1 Burial 2 Cremation 3 Removal from State Green Mount Crematory Balto, Md. Ponation 5 Other (Specify) ^{22. Name, and Address of Facility} Calvin B. Scruggs Funeral Home gxture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Preston St. Balto Md. Approximate Interval Between Onset and Death Approhen

Due to for as a consequence of): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner cancel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (of as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal dea☐ Pregnant at time of death 2 Eetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completely filled in by the funeral director, page 2 should be Yes Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 🗌 No 2 1 No Be 25. Was case referred to medical 26. Place of Death Check only one examiner?
1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 1 Inpatient 3 🗆 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural Injury 2 No 1 Tes 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🖵 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month) 9 2010 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 2010 ennett 110 1726 M ecember Medical 4a_Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death of Death ounty hever . Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 54 1 M 2 F Day Hours Min. Country) Director Yrs Usual Residence of Decedent or 28a-f show 10a. State filed within 72 hours after death with the Maryland Examiner must be notified at 10b. County 10c. City, Town_or Location 10d. Inside City Limits Director 1 Nes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 16010 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give 2 110 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Klac Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical-15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) life, DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 2 owx 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation Other (Specify) 21. Signature Fureral Service Lice 22. Name and Address of Facility mara 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart fallure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 honth Year Day Pregnant at time of death ate has been signed by the a page 2 should be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 2/ 1 Ves 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr. Cheverly Md. 20785 Dimensions Health Corp. Demetrios Catevenis 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar HMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 23a. Pt. I b., 25, 27, 28a-f, per me, g932 10-2-12 sm

State of Maryland / Department of Health and Mental Hygiene 2 12 sm State
 Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death NOTTHWE MMER TOUV 1 Year 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1 M 2 D F Months Days Month, Day, Director Usual Residence of Decedent or 28a-f show 10b. Cou 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. and Mental Hygiene. is marked other than "natural", or ξ 1 Never Married 2 Married 2 N M6 21215-0036 If Yes, Give Year or Dates 1 Yes 2 146 Specify. Specify: Completed 3 Divorced 4 Divorced Sac 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry UNK (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itimore Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Somure of Funeral Service Licensee Tru 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Pneumonia Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Right Humerus Fracture Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or se a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No Yes 1 Yes 25. Was case referred to medical director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 X Accident 5 Pending 1 ☐ Yes 2 🙀 No subject fell Investigation Could not be 12-8-10 4:01 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 218 Sudbrook Lane. Pikesville, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Group Home within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number Name and address of person who completed cause of death (Item 232) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DONNA L BREADY DECEMBER 22,2010 6:25A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔽 Days Hours Feb 15, 1954 Director Maryland 56 212-64-2987 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits Maryland Frederick Thurmont. 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 335 W. Main Street Lot 76 21788 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 XDivorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Herman Bready Beatrice Ann McGrady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth McCurry/sister 6900 Old Landover Road Landover, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 12/29/2010 Flinal Woodbine, Maryland 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 thomas atinou M00957 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 10 Medical resulting in death) Examiner Sequentially list conditions if any hading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Unknown Year the the been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has I autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes ည 1 Ninpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident s after deat | Director, Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) MD. 12-22.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g910 12-29-10 vt State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Beverly Clare Behrens $a^{\,\text{M}}$ December 2010 06:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlestown Care Center Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12 - 21 - 19 29 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 217-26-0057 81 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, Its Nedical Examinations to be mainful at 1 □Yes 2 No Director MD Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6843 Littlewood Court 21784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2KNo Specify: 2 Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary **BGE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Roy Joseph Foresti Katherine Julia Kirk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Beavan/Daughter 6843 Littlewood Court; Eldersburg, MD 21784 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral 12-29-2010 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, Maryland 21228 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that of 1st d the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCVD disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No Division of Vital 1 □ Yes funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: / investigation 1 ☐ Yes 2 ☐ No filled in by the Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Docember 75 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO. Myla Carpenter Box 5010 Laurel, Md. 20726 31. Date filed (Month, Year) Paristrar's Signature State 2 Registrar

Behrens

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			7695 01d 5. Social Security N	Rockbridg		(In vrs la	ast birthday)	If Unde	E1	kridge If Under 24		Date of Bi	rth			e (State o	r Foreian	
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121	led w Hygie her ti		12 17. Father's Name (First, Middle, Last)					ecre		18. Mother's	Name (F	iret Middle	Maido		Research Image: It was a state, zip Code) Maryland 21075 In - City or Town, State Burnie, Maryland Funeral Home at kridge, MD 21075 Approximate Interval Between Onset and Death D A S Date of delivery Month Day Year Date of delivery Month Day Year			
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3altimore,	permit. Pages 1 and 2 si Department of Health an Important: If item 27 is using any Injury or other trau		21. Signature of Fu	ineral Service Lice s	see O		22	. Name a	and Address	s of Facility	Gary	L. Ka	ufma	an Fune	eral	Home	at	
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P.O. Box	the Hospital or Attending Physician: The law requires that the death ce hin 24 hours after death. Thin 24 hours later death this certificate has been signed by the attendit the Funeral Director. After this certificate has been signed by the attendit mpletely filled in by the funeral director, page 2 should be detached for use	Physician//	23b. Was deceden in the past 12 1 Yes 2 5 Unknown	months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	Petal	death 3 [Ectopic Other (s	pregnancy specify)						-		/ear	
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>	Physicl rthis cer ral direc	To B	examiner? 1 ☐ Yes 2 🔽	Mo	Hospital: 1 ☐ Inpatier	nt 2 🗆 E	ER/Outpatier	nt 3 🗆 D						6 ☐ Other (Specify)			
0 4	ding Ph h. After th funeral	Ë	27. Manner of Deat	h 5 Pending	28a. Date of Injury (Month, Day)	y Year)	28b. Time of Injury		28c. Injury Work?	at				iry occurred				
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	To th withir To th comp	Me	29b. Signature and	title of certifier				29	9c. License	number			29d. Da	ate signed (N	onth, Da	ay, Year)		
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	4		30. Name and addr	ress of person who c	ompleted cause of de	ath (Item	23a) (Type,	Print)			0	to	110	(0)	vm	bee		
	U		Shala	nmale	2 Supl	< 9	1650	Jer	nhe	o nd	36			NO	71	045		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 10:40 A M Rosemary Buck December 21 2010 G. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Augsburg Lutheran Home

5. Social Security Number | 6. Sex Lochearn Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Director 88 217-14-5570 Aug. 19,1922 MDUsual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shairy hours or other traumatic event, it a MacTer Examine matter notified. Director 1 ☐ Yes 2 🕅 No Baltimore Lochearn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6811 Campfield Road 21207 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: <u>Ş</u> 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd Miller Bunting Gertrude Rose Desch ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laurence Buck Son 14 U Hillside Road; Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 12/27/2010 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Linensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Irijin) that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has e Hospital or Attending Physician: The I 24 hours after death. e Funeral Director: After this certificate h 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Hospital: 1 ☐ Yes 2 🔀 🗓 o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D4768 12/22/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Smith horne Sute 203 Balkner MD 2120 9 Kaymona Mille 2835 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Amend Item 25 per me, g910,12/29/2010dhb
Registrar

State Of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edward 2010 7:30 AM Pau1 Bosch November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 300 North Chapelgate Lane Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Hours Min. Oct. 18 Director 212-26-7621 82 1928 Mary Land Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🛛 Yes 2 🗌 No MD Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 300 North Chapelgate Lane 21229 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other transman. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ White If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 Divorced 4 Divorced Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ George Bosch Mary Reisig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin Bosch Brother 2115 Ganton Green Unit 211; Woodstock, MD 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Atlantic Crematory 12/2/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 998 Lineral Obstruction Medical Examiner Due to (or as a consequence of) 99 Upneu Sequentially list conditions, Due to (or as a consequence of). ll any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CENTIFICATION APPROVED BY MEDICAL EXAMINER Exami the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 056214 that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 🗆 No cate has been signed by the page 2 should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours a the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar Louis

31. Date filed (Month, Day, Year)
DEC 2 9 2010

419 W Roch

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene 2 1 State of Maryland / Department of Health and Mental Hygiene 2 1 Per me, g910, 12/28/2010dhb Registrar Reg. No. +0926 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 - Pay Physician/ NWOVE ESSIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Richey House Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, 1 🗆 M 2 🔀 F 51 Director 213-76-5764 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 623 N. Ellwood Avenue 21205 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1xXNever Married 2 Married Completed by 1 Yes 2 X No If Yes, Give Baltimbre, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) First Team Elementary/Seconday (0-12) College (1-4 or 5+) Staffing llth grade Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry L. Brown Evelyn Smalls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole Peaks-Daughter Ν. Ellwood Avenue Balto,MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mt Carmel Cem 12-17-10 4 Donation 5 Other (Specify) Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res, iratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Enysician/ disease or condition resulting in death) Medica Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes 2 X 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \)Other (Specify, 은 1 Inpatient 2 ER/Outpatient 3 DOA of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Watural 5 Pending injury Division Investigation 6 Could not be Accident 3 Suicide
4 Homicide within 24 hours after de To the Funeral Director completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) H0064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linden Av. Balt, MD. 21201 31. Date filed (Month, Day, Year) State Registrar's Signatu 0 9 Barke Registrar

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State of Maryland / Department of Health and Mental Hygiene 2 U | U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24^{Day} Physician/ Louise Blake 20°T0 6:35 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Hospital Harford Belair 9. Birthplace (State or Foreign Country) MD 7, Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Davs Hours 1 □ M 2 F 2 - 15 - 1927 Director 212-24-7843 83 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Joppa Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1503 Gunpowder Ridge Road 21085 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th grade College (1-4 or 5+) Waitress S&E Resturant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o Major Wilson Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2422 Windsor Road Parville, MD 21134 Olando Blake-Son 2422 Windsor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Community Bapt Ch 12-30-10 Joppa, MD 21. Signature of Funeral Service Licenses March East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Iding physician and Ise as the burial-tran Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Tes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 716 Hart M.Dford Kodd 32. Regi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 3:45 a M Arthur Barnes, Sr 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges St Thomas Moore Skilled Nurse Hyattsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 M 2 □ F 72 231-38-1248 **Director** 4-13-1938 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2314 Aiken Street USA 21218 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Fork Lift Operator Coke Cola 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph B. Barnes Ollie Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Barnes-Wife 2314 Aiken Street Balto, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Date King Memorial 12-30-10 Ponation 5 Other (Specify) Randallstown, re of Funeral Service License igna 22. Name and Address of Facility March East F/H 1101 Balto, MD21202 North Avenue art 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause in each line. Approximate Interval Between nmediate Cause (Final 4 lburoschook Onset and Death Physician/ ase or condition ulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' death? Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work hours after death. neral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Let use the cause of the cause 29a. Certifier completed (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year 29 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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LaSale Rd

Hyatsville, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ROSALIE MARIE BRANDT 13 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square 405Pita more tranklin Date of Dis (Month, Day, 13 Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 ☐ M 2**X X**F Months Days Hours Min. Director 61 212-52-9742 Dec Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland Baltimore Perry Hall 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 34 Sandstone Ct. 21236 **USA** items . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Me fical Examin once. ģ 1 Never Married 2 Married Rosal Baltimore, Maryland 21215-0036 ☐ Yes 2XXX No 1 Yes 2 X No Specify: If Yes, Give Specify:White 3 Widowed * Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Hair Dresser <u>Hairstyling Industry</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell B. Harper Rena Margaret Grubb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Stacie Lynn Brandt (Daughter 5120 Key View WAy Perry Hall, Md. 21128 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12-24-2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsvill 7. Jaseahs <u>Kingsville</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or linjury Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Month Day Year 5 Other (specify) the Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မှ 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No : After t 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December no 20 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank Square Drive 31. Date filed (Month, Day, Year)
DEC 2 9 2010 32. Registrar's Signature State

Registrar

10-09885 George Bryson, Jr.

Please Type or Print in Black Indelible Ink. Ensur State of Maryland / Department of Health an Certificate of Death		0 4093
Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
George Raleigh Bryson Jr.	Month Day Year	2011 hrs

	1- For State Registrar		tificate of Death	Reg. No.	0 70701
Physician/ Medical Examine	1. Decedent's Name (First, Mid George Ralei	dle,Last) .gh Bryson Jr.	2. Date of Death Month Day Year December 22, 2010	3. Time of Death 2011 hrs	
	4a. Facility Name (if not instituted I 95 SM, South of Ro	h 4c. County of De Howard	4c. County of Death Howard		
Funeral Director	5. Social Security Number 241-25-2587	6. Sex 7. Age (In yrs. la	ast birthday) If Under 1 Year If Under 24Hr Months Days Hours Mir Yrs. Mir	1Fo	Birthplace (State or reign Country) NC
Maryland 28a-f show any 1 at once. ector	Usual Residence of Decedent 10a. State 10b. County NC Rock:		Town or Location		10d. Inside City Limits 1 Yes 2 No
t the Maryland 3a or 28a-f sh biffied at once	10e. Street and Number 1852 Moir Mi	ll Rd.	10f. Zip Code 27320	10g. Citizen of What C	country?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. net: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 1 3 Widowed 4 X D	1 Yes 2 No	S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- b Rican, etc.) 14. Race - An White, etc Specip 1a	ck
5-0036 ed within 72 hours lygiene. other than "natus the Medical Exam Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12		Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret Truck Driver	work done irred) 16b. Kind of Busines Transpo	•
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical To Be Comple	George Ralei	gh Bryson Jr.	18.Mother's Name Inez Ma 19b. Mailing Address (Street and Number or	e (First, Middle, Maiden Surname) Vnard Rural Route Number, City or Town, St	ate, Zip Code)
ore, MD 2 ss 1 and 2 shou of Health and N If item 27 is pher traumatic	William Jerr 20a. Method of Disposition 1 XBurial 2 Crematic	20b. F	1316 Branson Dr. G Place of Disposition (Name of cemetery, remailory or other place)	Date 20c. Location - City	or Town, State
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun	4 Donation 5 Other S 21 Signature of Funeral Service	Specify:Ber	naja Church Ceme. 222. Name and Address of Facility Mc. P.O. Box Reidsy:	Laurin Funeral	
Physician /Medical	23a. Part I. Enter the disease, q failure. List only one caus Immediate Cause (Final diseas	on each line.	Do not enter the mode of dying, such as cardiac of		Approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence of b.):		
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a consequence of Due to (or as a consequence of			
executed an and all - transit		d. AMENDED	,		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transied for a few page 2 should be detached for use as the burial - transied for a few page 2 should be detached for use as the burial - transied for a few page 2 should be detached for use as the burial - transied for a few page 2 should be detached for use as the burial - transied for the few page 2 should be detached for use as the burial - transied for the few page 2 should be detached for the page 3 should be detached for the purification.		23c. If yes, outcome of pregn	2 Fetal death 3 Ectopic pregna	23d. Date of delive Month	rery Day Year
IS, P.O. Be quires that the densigned by the uld be detached ted by Phy			sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 P 24a. Was an 24b. Were	
Vital Records, vician: The law require in secreticate has been significate has been significate has been significate by Should be director, page 2 should be do Be Completed	25. Was case referred to medical	al	26. Place of Death (Check	autopsy prior to death 1 Yes 2 No 1 V	o completion of cause of
Division of Vital Records, P.O In or Attending Physician: The law requires that the state death. The law requires that the sertificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by Fertification: To Be Completed by Fertification:		28a. Date of Injury (Month, Day Year) ding Dec 22, 2010	ER/Outpatient 3 DOA Other Nursin 28b. Time of Injury 2010 hrs 1 \infty Yes 2 No	ng Home 5 Residence 6 Otl 28d. Describe how injury occurred Driver of tractor-trailer at hig	
Division o spital or Attending nours after death. Indeed Director: Aft nitied in by the functoritified in by the functoritification:	3 Suicide 6 Cou	ld not be armined (Specify) Major Road	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or or Town, State) I95 SB, South of Route 175, Sha	
To the Hos within 24 hr To the Fun completely	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exc 29b. Signature and title of certifi	miner: On the basis of examination and manner stated.	e, death occurred at the time, date and place, and dor investigation, in my opinion, death occurred a 29c. License number		the cause(s)
34	30. Name and address of person Victor Weedn MD JD	who completed cause of death (Item: Assistant Medical Examin		December 23,	2010
State	31. Date filed (Month, Day Year				
Registrar		9 2010 Charles	ORIGINAL ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40931 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:49 AM Sonya Burger Medical DECEMBER 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 04 imore last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. (Month, Day, Year) 9 24 1 □ M 2 💢 F Hours Country) 212-44-9172 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD NA 1 Yes 2 No Baltimore 10e. Street and Numbe 10g. Citizen of What Country? Funeral items 23a 4800 Seton Drive <u> 21215</u> U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces 9 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural" Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic access." 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) formation Systems .2th grade 2yrs Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Sonie Turnipseed <u>Roberta Crosby</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1830 Hope Street, Baltimore, Md 21202 Patrice Turnipseed-Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 C Other (Specify) <u>Garrison Forest</u> Vet 01/03/11 Owings Mills, Md 21. Sign March F/H West 4300 Wabash Ave, Baltimore, Md 21215 of Funeral Service License Part I. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fielder. List only one cause on each line. 23a. Part Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ DIAbelt Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Peryohand that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical sessivase Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month ned by the a s been signed I should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [조 Dementie Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Maemie has page 2 s autopsy performed Yes 2 the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ္ဝ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred atural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Hospital 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Children Practitudes of the Control of the Co within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ~D D 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. HASHMI SHACH 2 821 N. FUTAW ST Pinte 308 BALTIMORE MD 21201 MD 31. Date filed (Month, Day, Year) gistrar's Signature

Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G911 1/07/2011 JH State of Maryland / Department of Health and Mental Hygiene 2 U State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 10:50P <u>December</u> Edith Brenton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Perry Hall 8621 Jessica Lane 21355810830 212-50-3965 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Days December 1950 Commy yland Months Hours 60 Yrs **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 No Balto. Perry Hall Md. 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral USA 21128 8621 Jessica Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ρ should be filed within 72 hours after and Mental Hydiene Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dolores V. Matthews Edward P. Winkler or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trae Towson, Md. 21286 Son 1653 Thetford Road Paul Brenton 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joseph 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 12-31-2010 Fullerton, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death Physician/ EMIT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the a Yes 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 2 No Ves 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No Notice that is the state of the state of the state this contracted filled in by the funeral different state of the state o ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES ST. BALTMONE, NO. 21208 569 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PM Patrick Nathaniel Bright 300 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Jown, or Location of Death County of Death posedale altimore ranhlin SIDI If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Months Days Hours Min. October 5,1946 Country) Maryland Director Vrs 214-44-6713 64 Usual Residence of Decedent or items 23a or 28a-f shov miner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County Director 10c. City, Town or Location 10d. Inside City Limits Md. Balto. Middle River 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Tidewater Lane 21220 IISA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry Medical Books (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Publisher Editor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Bright Lollie Marie Branch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lynn Bright Spouse 400 Tidewater Lane Middle River, Md. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 12-29-2010 4 Donation 5 Other (Specify) Bayview Balto, MD. up ral Servic Licens 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Muocardia Medical resulting in death) Examiner stinal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 2 No Yes ed by the a Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes certificate has been si irector, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Medical within 24 hou

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completed fil 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier ecember abiaolo Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Galtimore, MD 21237 Square 9000 Franklin

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

10-09960
Austin Burnopp

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day December 24, 2010 Medical Examiner 2355 hrs Austin Burnopp 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 120 Gambrills Road Anne Arunde 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. Director 217-15-9648 05/12/1983 Country) 1XXM 2 F 27 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 XXNo 28a-f show l other than "natural", or items 23a or 28a-f sho the Medical Examioer must be notified at ooce. Severn Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21144 120 Gambrills Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Armed Forces? 2 X No Yes Specify: White If Yes, Give Year 1 Yes 2XX No specify: 4 Divorced 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "violury or other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Recycling Equipment Operator 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley A. Varney Be Jacob A. Burnopp, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn, MD 21144 120 Gambrills Road Mrs. Shirley A. Burnopp/ mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 12/30/2010 Elkridge, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Seneral S Services,PA 1 2nd Ave. SW Glen Burnie, MD 21061 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiac Arrythmia due to Cardiomegaly with 23a, Part I, Enter the disease, or complications that causes **Physician** Between Onset and **IMedical** Death Biventricular Dilatation and Mild Myocardial Fibrosis Immediate Cause (Final disease xaminerگھ or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - trans Physician/Medical AMENDED 23a,27 per me g912 2-4-11 vt X UNPENDED Box 68760, he death certificate be e IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Live birth 2 Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene this 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: 1 X Natural death. 1 Yes 2 No Director: 5 Pending 2 [Accident in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) within 24 hours a To the Fuoeral I determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedlcal Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 25, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, pt1, ITperPHYS, G914, 4/11/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bland Physician/ Month Year onald P 134 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Howard Columbia Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCt. 26, 1939 9. Birthplace (State or Foreign Country) KY **Funeral** 1**X** X M 2 □ F Days Hours Min. 407-52-5493 Director 71 Usual Residence of Decedent or items 23a or 28a-f show Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Jessup 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9190 Vollmerhausen Road 20794 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1
Never Married 2
Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Divorced 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Bookbinder Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Blair Dorothy Mae Sparks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lana Louise Blair/ Wife P.O.Box 33, Savage, MD 20763-0033 20a. Method of Disposition 20b. Place of Disposition (Name of December 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 25 Cremation 3 Removal from State West Arudel Crem. Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Ken Stiles 313 Talbott Ave., Laurel, MD 20707 M01053 23a. Ourt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pneumonia Immediate Cause (Final disease or condition Enysiciani Medical resulting in death) Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NSTEMI 1 Yes 2 No 3 Probably 4 Unknown Completed severe COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy NSTEM certificate 1 Yes 2 No Yes 2 - No Hospital or Attending Physician: 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Tes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

Director: After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 00066 515 M. D 20 2016 Dec 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Charter Dr., Suite 310, Columbia, MD 21044 ed 1 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 22, 2010 JONATHAN LESLIE BUCK 5:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 12209 Valerie Lane Laurel Prince George's 5. Social Security Number 6. Sex 8. Date of Birth If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign XXM2 F Days Dec. 1, Year 1953 Min. Maryland 220-62-9160 **Director** 57 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Laurel 1 Yes 2 XX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12209 Valerie Lane 20708 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 Ko
If Yes, Give Black, White, etc. 1 Never Married 2 XX arried Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) years Registered Respiratory Ther. Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Paul C. Buck Arlene Klug 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie M. Buck 12209 Valerie Lane spouse Laurel, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XXremation 3 Removal from State West Arundel Crem. 12/23/2010 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee ²²Name and Address of Facility ral Home, P.A. CR / M00770 313 Talbott Avenue 20707 Laurel, <u> Maryland</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Immediate Cause (Final 29nset and Death Physician Metastatic Testicular Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death ned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 🛛 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2XXNo 2**XX**N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2XXNo 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After to in by the funers 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Division of Vital Records, hours after within 24 hours a To the Funeral I completed filled

12

State Registrar

Medical

29a. Certifier (Check

29b. Signature and title of certific

Rita Pabla,

Baltimore Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D 47707

Laurel, Maryland

29d. Date signed (Month, Day, Year) December 22, 2010 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - For State Registrar	State of Ma	aryland /		artmer <i>tificat</i>			and M		giene Reg. No. 201	0 40937	
Г	Physicia	ın/	1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	th Day Yea	3. Time of Death	
	Medic Examir	cal	Donald 4a. Facility Name (if not institution, give	e street and number)	Benick	ς	4b. City,	Town, or I	Location of	f Death	Decemb	er 27, 20	10 5:15 p ^M	
· •	/		4505 Sandwood 5. Social Security Number 6, 8				If I lead a	- 4 Ve I	Edge			Ba	altimore	
	Funeral Director		199-22-1312	XM 2 □ F	e (In yrs. last bi		If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, September	(Year)	Birthplace (State or Foreign Country) Pennsylvania	
	and show Lat	j	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Loc							10d. Inside City Limits	
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	with the	Funeral Director	10e. Street and Number 4505 Sandwood	Road			10f. Zip	Code	2121	9		10g. Citizen of What (
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒️Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	ver in U.S. No	11	Vas Deced Yes, spec	city Cuban	, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)	14. Race - An Black, Wh	nerican Indian,	
Maryland 21215-0036	n 72 hour e. ian "natu Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	ducation		(Give k	ent's Usua ind of wor NOT use	rk done du	tion Iring most	of working	g	16b. Kind of Busines	s Industry	
27	filed withi al Hygiene d other th	Be Co	12 years 17. Father's Name (First, Middle, Last)				Sup		coord.				skay_	
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, Mar	ロイトコ		19a. Informant's Name/Relationship (7 Denise M. Flohi	ype, Print) Daught	ter 19	b. Mailing	g Address 3 Ca i	(Street ar n ter k	od Number	or Rural i Lane,	Route Number, Falls	City or Town, State, 2 ton Md. 21	Zip Code) 047	
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other ance.		20a. Method of Disposition 1XI Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		20b. Place cemet Sacre	ery, crem	atory or o	ther place,	sus I	Decen	nber 2010	20c. Location - City of Dundalk,		
Balt	permit. Page Department of Important: II any injury or once.		21. Signature of Funeyal Service Licens	Con	nelle	22.	Name an Coni 711	d Address	of Facility Fundalers	eral Poir	Home O	f Dundalk, Dundalk,	P.A. Md. 21222	
	nysician/		23a. Part 1. Enter the disease, or come shock, or heart failure. List only commediate Cause (Final disease or condition	N.L.			r the mode	e of dying,	such as ca	ardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death	
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, r.	es that th signed by I be detac	ا ۾	Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the un	derlying c	ause give	n in Part I.		23e. Did tob	N_4 _	to the cause of death?	
Vital Records,	w requii s been 2 should	Completed	Prostate Car	1565		-					24a. Was ar	24b. Were a	Probably 4 Unknown utopsy findings available	
Ke	: The la cate ha										autops perforr 1 Yes 2	ned? death?	o completion of cause of	
<u>E</u>	sician certifi irector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:				Othor	e of Death					
5	ng Phy fter this ineral d	ate: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,	nt 2 ER/O y 28b. Year)	utpatient Time of injury		Bc. Injury a work?			$\overline{}$	nce 6 Other (Spe w injury occurred	ncify)	
DIVISION OF	r Attendi er death. rector: A by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		y - At home, fa	arm, stree	M et, factory,	M 1 ☐ Yes 2 ☐ No factory, office 28f. Location (Stree					et and Number or Rural Route Number.	
5	ospital o hours aft ineral Di d filled in	Medical C	29a. Certifier Certifying Phys	sician: To the best of n	ny knowledge.	death oc	cured at t	the time, d	ate and pla	ace, and	City or Town	se(s) and manner as s	tated.	
	o the H ithin 24 o the Fi omplete		(Check 2 ☐ Medical Examination only one) 3 ☐ Certifying Nurse 29b. Signature and title of certifier	e Practioner: To the b	est of my know	r investig ledge, de	ath occur	ny opinion, red at the t License n	ime, date a	urred at th ind place,	and due to the	d place, and due to the cause(s) and manner a 9d. Date signed <i>(Mon</i>		
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•	5 V		30. Name and address of person who o	ompleted cause of de	ath (Item 23a)			BALL	Sm. P	М	D 2123	7		
H	State Registra	e	31. Date filed (Month, Day, Year) UEC 2.9 20		's Signature			<u>~11()</u>	111100	, (. 0100			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / Dep	partment of Health and I	, ,	211111 111938				
			Registrar 1. Decedent's Name (First, Middle, Last		Tillicate of Death	Reg. N	3. Time of Death				
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	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		c. County of Death				
ı	Examili	ei.	The Johns Hopkins Ho	spital	Baltimore City						
Ī	Funeral Director		217-30-6380	× 2 ☐ F 7. Age (In yrs. last birthday 4 / Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)				
	and Sw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location		10d. Inside City Limits				
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	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.				
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	,,	Specify: , \ / /				
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Maryland	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (T)	pe. Print) 19b. Ma	iling Address (Street and Number or Re	iral Route Number, Cit	2.3				
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Jor	Pages nent of I int: If its iry or o		1 ☐ Burial 2 √Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State cemetery, cr	romaton, or other place)						
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service, Licens	17771004176	22. Name and Address & Facility	29-10 HI	LAN FUNERAL HOME,				
Ba	permit. Departn importa any injt		VIIII		PA, 2134 W, 110 W	Spring A	20ad , 21222				
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do not e	enter the mode of dying, such as cardia		Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Sequentially list conditions,								
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Box	w requires that the death certif been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year				
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	ires the	d by	.		, , ,	1 ☐ Yes	2 No 3 Probably 4 Unknown				
Ö	requisions	lete				24a. Was an	24b. Were autopsy findings available				
Re	The law ate has t page 2:	Completed				autopsy performed?					
ta			25. Was case referred to medical		26. Place of Dea	th (Check only one)	1 163 2 100				
of Vital Records,	ysicia s cert direct	To Be	examiner? 1 □ Yes 2 🔀 No	Hospital: 1 ⊠ Inpatient 2 ☐ ER/Outpati	ient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐ Other (Specify)				
0	ig Ph ter thi neral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time	y Work?	28d. Describe how in	njury occurred				
Sio	eath. or: Af the fu	catio	2 Accident investigation 3 Suicide 6 Could not be	DOS Disse of injury. At home form	M 1 Yes 2 No	206 Langting (Street	and Number or Bural Boute Number				
Division	or Att	Certification:	4 Homicide determined	28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	City or Town, Sta	and Number or Rural Route Number, ite)				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director,			ysician: To the best of my knowledge, de							
	e Hos n 24 h e Fun	edical	(check only one) 2 Medical Exam	iner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	urred at the time, date	and place, and due to the cause(s)				
	Vithir comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)				
			Kull	and the same of th	Rts-000	De	iemBer 25, 2010				
	61			completed cause of death (Item 23a) (Typ		Nauda Mi-16-	Ot Daltimore MD 04007				
	4 *		KAR THIK JUN 31. Date filed (Month, Day, Year)	€ Registrar's Signature		North Wolfe	St, Baltimore, MD, 21287				
Ī	Sta Registr		DEC 2.9 2010	2. Registrar's Signature	aled						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17&18 Per FH C911 1/12/2011 JH State of Maryland / Department of Health and Mental Hygiene amend #8&10g Per FH G911 1/14/2011 Heath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Christine Barrett 2010 4:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, **96**, Year) 1950 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2XX Yrs. Director 60 220-84-7567 Australia Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Mustralia, Funeral 19354 Keymar Way 20886 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give ו "natural", or item ledical Examiner וו 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Law / Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julian Rex Barrett Cowell Ashfor ပ Barrett Rita Mavis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Jordan / Friend 6806 Lamp Post Lane, Alexandria, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 X Cremation 3 Removal from State 12/27/2010 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Lice Rapp Funeral and Cremation Services M00382 Tylight Kolun 933 Gist Ave., Silver Spring, 20910 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Metastatic Lung Cancer disease or condition vear Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or iinjury the burial-transi attending physician and resulting in death) Last Due to (or as a consequence of): certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 XNo that the death page 2 should be detached for Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by requires of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law I has autopsy certificate 1 Yes 2 No 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 XNo ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division Accident
Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined thin 24 hours a the Funeral Dimpleted filled Medical 1XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0060117 December 23, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Joon-Shik Park M.D., 8600 Old Georgetown Rd., Bethesda, MD 20814 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **DEC 29 2010** Registrar DHMH 17 Rev 7/2009

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CHRISIN

BARRELIE,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Ker 8:5 7105 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** estmins Carrol 50 . Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Davs Hours Min. Month, Day, Year 216-32-4813 Director Jan Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Carrol1 Manchester 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3316 Wilhelm Lane 21102 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race ~ American Indian med Forces?
☐ Yes 2 ☐ XNo Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+ owner of assisted living health care Be permit. Page 1 and 2 should be fileo Department of Health and Mental Hyg Important: If item 27 is marked any injury or other transcene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Helen Vaughn Albert Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Tatum (daughter) 12520 Thoreau Dr., Chesterfield, VA 23832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State metery, crematory or other place) Old Oakland Cemetery 12-30-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Hau P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complimations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1000 Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Dove House မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Matural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Month, Day, Year)

State

Name and address

Registrar

th Could Streat

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Horatio Orville Berwick Medical Decembe: 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3 Hullihen Drive Elkton Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 01/26/1929 **Funeral** 9. Birthplace (State or Foreign Country)

St Virginia Days Hours Min. 1 X M 2 🗆 F Months 163-22-6097 Director Yrs 81 West Usual Residence of Decedent or 28a-f show notified at show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Cecil 1 Tes 2 No Elkton 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 3 Hullihen Drive U.S.A. 21921 within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 2 X No 1 ☐ Yes 2 If Yes, Give Year or Dates. 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Superintendent Education Be traumatic event, 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) ၀ and 2 should be William Henry Berwick **Emma** Higinbotham Κ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Joan Berwick / Wife 3 Hullihen Drive, Elkton, MD 21921 Important: If item 2 any injury or other other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State jo ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 12/29/2010 Hanover, Maryland Signature of Funeral Service Linens. 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Vev disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) the Hospital or Attending Physician: The law req ir s that the death certificate be executed the burial-transit Cause (Disease or it that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year 2 No the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital 1 🗌 Yes ျာ 1 Inpatient 2 ER/Outpatient 3 I DOA Director: After this d in by the funeral di 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature ar ne and address of person who completed cause of death (Item 23a) (Type, Print) 133 MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 Month **Physician** 7avin December 2010 John /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Ye Dec. 31, 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 2008 Dec. 699-10-0420 **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location or 28a-f show notified at 10a. State 10b. County 1 ∑ Yes 2 □ No Director Culpeper Virginia Culpeper 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō Pages 1 and 2 should be filed within 72 hours after death with ral", or items 23a o Examiner must be U.S.A. 22701 825 Lakeland Court Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) al Hygiene. N/Athe N/A0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ilth and Mental H 27 is marked of traumatic ever Amber Nichole Humphreys John Anthony Beltran မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 825 Lakeland Ct., Culpeper, VA 22701 Health i John Anthony Beltran (Father) permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition cemetery, crematory or other place) 1 🕅 Burial 2 □ Cremation 3 □ Removal from State -28-10 Denation 5 Other (Specify) Warrenton, VA Bright View Cemetery 22. Name and Address of Facility ature of Funeral Service License Pierce Funeral Home 9609 Center St., Manassas, VA 20110 Mun Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) cardine airest /Medical Due to (or as a consequence of): Examiner Due to (or as a sequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Acute Myelogenous as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records. 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: Inpatient 2 No 2 ER/Outpatient з □ DOA 1 Tes ၉ this 28a. Date of Injury (Month, Day Year) Manner of Death
Natural
Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No death. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide

Hospital or Attending Physician; Director; / 24 hours within 2 To the F

State Registrar

Gestagmi Dheeval 31. Date filed (Month, Day, Year) 32. Registrar's Signatur 2010 **DEC 29**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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29a. Certifier

one)

(check only

29b. Signature and title of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

20069439

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

December 20 2010

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		For State Registrar	State of	Maryiani		rtificate of L	ealth and Mo	, ,	71111	40943
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Physicia /Medic		Maybell	Brou	20			+	Month Decembe	Day Year	6 : 10 M
Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of Death	O C COLVE	4c. County of Dea	
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Funeral	<u> </u>	· · ·	Sex 7	. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign ountry)
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and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
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d be ental ced o	To Be	Johnson Keels	7				Emma Gi			
shoul nd M mar	ř	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street a	and Number or Rura		City or Town, State,	Zip Code)
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permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Inspartment of Health and Mental Hygiene. Inspartment of Health and Mental Hygiene. Inspartment It flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate		. Cemeter	·	2/10	Cheektowa	ga. NY
permit. Departr Imports any Inju		21. Signature of Funeral Service Lice	ensee	'	22	2. Name and Addres	s of Facility Lom			
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		23a. Part1. Enter the disease, or con shock, or heart failure. List onl	nplications that car y one cause on eac	used the death ch line.	. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arres	t,	Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (o	r as a consequ	ience of):					
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uted	min	Sequentially list conditions, if any, leading to immediate cauds. Enter Underlying Cause (Disease or injury								
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death certificate attending physic at the second to the second the second to the second	Medi									
ith ce tendii r use	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome pf pregna th 2□Fetai	ncy I death 3	Ectopic pregnancy			23d. Date of de	,
ne dea the at hed fo	Physician/Medic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unknov	nt at time of do	eath 5	Other (specify)			Month	Day Year
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iclan: Th certificate ector, pag	Be C	25. Was case referred to medical					26. Place of Death			s 2 No
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. D		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury	28c. Injun Work	/ at 2	8d. Describe how	injury occurred	
Attending r death, ector: After by the funer	catic	2 Accident investigation 3 Suicide 6 Could not	ho I				Yes 2 □ No			
or At ifter d Direct in by	Certification:	4 Homicide determine	28e. Place o	of injury - At ho g, etc. <i>(Specif</i>)	me, farm, str /)	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
spital ours a neral filled	2	29a. Certifier 1 Certifying F	hvsician: To the b	est of my kno	wledge, deat	h occurred at the tin	ne, date and place, a	and due to the car	ise(s) and manner:	as stated
To the Hospital or Attendin within 24 hours after death To the Funeral Director. Aft compietely filled in by the fur	ledical	(Check only one) 2 Medical Exa	aminer: On the bas and manne	sis of examina	tion and/or in	vestigation, in my o	pinion, death occurre	ed at the time, da	te and place, and di	ue to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier		v~		29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
		Jester y	20cm	V 3		12005	3337	D.	ecember	17,2010
		30. Name and address of person w								
	to.	31. Date filed (Month) Day, Year)	M 32. Rei	gistrar's Signa	ture	Trence	Ste 203	Dalti	uore, MIC	2(1209)
Sta Registr		DEC 29 2010 2	32. Re	8. Aa	wer					
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DHMH 17 Rev 7/2009

Registrar

10-10003 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anthony Albert Brocato State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Month Day December 27, 2010 Year **Medical Examiner** Anthony Albert 0207 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5 Adams Avenue Cockeysville **Baltimore County Funeral** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Hours Director 219-90-3740 46 9/9/1964 1 X M 2 F Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Cockeysville Maryland Baltimore 1 Yes 2 X No tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once, Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? U.S.A. 5 Adams Avenue 21030 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces White, etc. Yes White 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2 X No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hour
Department of Health and Mental Hygiene
Important: If tien 27 is marked other than "nati
nijury or other traumatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Insulation College (1-4 or 5+) Garage Door Insulation Contractor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Joanne Theresa Modesti Be Natale Joseph Brocato 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 19a. Informant's Name/Relationship (Type, Print) 5 Adams Avenue Cockeysville, Maryland 21030 Joanne Lamberjack / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv. Corp. 12/28/2010 Towson, Maryland Donation 5 Other Specify 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval een Onset and * /Medical Death Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED 23a, pt. II, 27 per me g913 3-24-11 vt ned by the attending physician detached for use as the burial -X UNPENDED Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l þ Chronic Alcoholism, Epistaxis, Obesity 1 Yes 2 No 3 Probably 4 V Unknown Completed page 2 should 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certifi upletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 🗸 Other Scene 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. December 27, 2010 Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mary	land / Dej Ce	partment of ertificate of	Health ar <i>Death</i>	nd Mei		iene 201	0 40946
			Decedent's Name (First, Middle, Last)				2.	Date of Death		3. Time of Death
	Physicia		Nannie Elizabeth Brown					Month 12	15 2010	ear
	Medio Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town,	or Location of F	Death	_ 1 2	4c. County of E	
	LAdillio	Ci	Ft. Washignton Health & Reha	h Conta					Prince (
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday			Hrs. 8.	Date of Birth	9	Birthplace (State or Foreign
	Director		229-24-9172 1 M 2 XF 87	Yrs.	Months Days			(Month, Day, 0	Year) 923	Country) VA
			Usual Residence of Decedent					05 05	7 1723	722
and	shov	5	10a. State 10b. County 10	c. City, Town or l	_ocation					10d. Inside City Limits
laryli	ifiec	ect	DC	Washingt	on					1 X Yes 2 ☐ No
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ath v	S III	Funeral Director	11. Marital Status 12. Was Decedent Ever	in U.S. 13		Hispanic Origin	2 (Specify	Yes or No-		American Indian.
e de	or it	by F	1 Never Married 2 Married 1 Yes 2 X No		B. Was Decedent of I If Yes, specify Cub		Puerto Rica	an, etc.)		Vhite, etc.
affer a	a", c		3 X Widowed 4 Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:			Specify:	Black
5 in [call	Completed	15. Decedent's Education	16a Dec	edent's Usual Occu	nation			16b. Kind of Busin	ann Industry
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м ре В	Hyg othe ent,	Be	17. Father's Name (First, Middle, Last)	1		18. Mother's	s Name (Fi	rst. Middle. Mi	aiden Surname)	,
yland uld be filed	ked ked ic ev	욘	Robert Harris			Dolli			and on our manney	
	mar mat		19a. Informant's Name/Relationship (Type, Print)	10h Ma	iling Address (Street				City or Town State	Zin Codo)
Man 2 sho	Ith ar 27 is trau		Ivory Brown/Son	1						, MD 20772
and and	Heal tem				position (Name of	id raim	Date		20c. Location - Cit	
ge 1	oro		1 KBurial 2 Cremation 3 Removal from State	cemetery, cr	ematory or other pla					•
Salulmore, permit. Page 1 and	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				onal Cemet					
er i	mpo my ir		21. Signature of Funeral Service License		22. Name and Addre					
		h 16	pruf Candelson		1217 9th					.1
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not er	nter the mode of dyi	ng, such as car	rdiac or res	spiratory arres	t,	Approximate Interval Between
	ysician/		Immediate Cause (Final disease or condition Acute Cer	ebrovaso	cular Acc	ident				Onset and Death
	Medical kaminer		resulting in death) Due to (or as a column and a column							10 400
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TI	#	dical Examiner	Sequentially list conditions, if any locking to immediate cause. Enter Underlying	meduenou offi.						
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ate b	g physician and is the burial-transit		d							
ertifica	ing p	Physician/Me	IF FEMALE:							
th ce	tend or us	ian,	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnan	су			23d. Date of	
dea	the at	/sic	1 ☐ Yes 2X No 4 ☐ Pregnant at tim 9 ☐ Unknown 9 ☐ Unknown	e of death 5	Other (specify)				Month	Day Year
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s the	ignec be d	by	Tart it. Other significant conditions contributing to death but its	or resulting in the	differrying cause g	iveii iii Faiti.				e to the cause of death?
or do.	sen s ould	ted					_ [1 L Yes	s 2.4∆ No 3.L	Probably 4 🗌 Unknown
aw re	as be 2 sh	ple						24a. Was an autopsy		autopsy findings available to completion of cause of
l le d	ate h page	Completed						perform	ed? deat	h? Yes 2X No
<u> </u>	rtifica tor, 1	Be (25. Was case referred to medical examiner?		26. P	lace of Death ((Check onl		¥ (2)	
ysic	is ce direc	10	Hospital:	2 ER/Outpati	ent 3 DOA Oth	ner: 4 X Nursi	ing Home	5 Residen	nce 6 Other (S	pecify)
5 6	ter th		27. Manner of Death 1 X Natural 5 Pending (Month, Day, Ye.	28b. Time	of 28c. Inju	ry at			/ Injury occurred	
5 mg	ath. nr: Af	lica	2 Accident Investigation	any mijary		Yes 2 □ No	0			
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를 를 다.	al Di ed in		building, etc. (o).	recity)				City or Town,	State)	
lospi	within 24 hours affer death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my k (Check 2 Medical Examiner: On the basis of exami	nowledge, death	occured at the time	e, date and plac	ce, and du	e to the cause	e(s) and manner as	s stated.
the H	the F	Me	only one) 3 Cortifying Nurse Practioner: To the best							
ō	Zon Con		29b. Signature and title of contifier	\supset	29c. Licens	e number		29	d. Date signed (Mo	onth, Day, Year)
					D-24	535			12/25/	2010
			30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)			<u>-</u>		
			Lamni Berwa, MD 7700 Old Br	anch Ave	enue, Cli	nton.MD	207	35		
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's 5			,				
	Registra	ır	DEC 2 9 2010 Burner B.	parke						

DHMH 17 Rev 7/2009

10-09922

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Alyssa Anne Ber		t 1- For State Registrar	Stat	e of Maryla		artment o ertificate o		and N	1ental H		2 0 Reg. No.	0 +094
Physicia Medical Exami	an/	1. Decedent's Nam	e (First, Middle,l LYSSA	ast) ANNE	BENNET					2. Date of De		3. Time of Death 0300 hrs
, j		4a. Facility Name (f not institution,	give street and nu	mber)		4b. City, Town	, or Loca	ition of Death		4c. County of D	
#		5. Social Security N		Medical Cente	7. Age (In yrs.	lost hirthdov	Glen Bur		U-d- 041	To Date of D	Anne Arun	
Funeral Director		215–31–023	_	M 2 ⊠ F	19	Yrs	If Under 1 Months		lours Min.	December	er 27,1990	Birthplace (State or Oreign Maryland Country)
b		Usual Residence of	Decedent				.1			pecenia	27,170	
how an		10a. State Maryland	10b. County	Arundel	10c. City	y, Town or Locat P₂	asadena					10d. Inside City Limits 1 Yes 2 No
farylan 28a-f si	Director	10e. Street and Nur		TH UNCL		16	10f. Zip Cod	le			10g. Citizen of What	
th the N		833 Turf	Valley Dr	ive				21122	2		U.S.A.	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. Laut: If item 27 is marked other than "natural", or items 23s or 28s-f show any or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 Never Marrie 3 Widowed		4	2 🔀 No	J.S. 13. Wa	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. Yes 2 No specify:			ecify Yes or No Rican, etc.)	o- 14. Race - A White, e Whi Specify:	
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5-00 led wit Hygien other		17. Father's Name (,		I.	Tearing	18.Mc	other's Name	(First, Middle,	Maiden Surname)	
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MD 2 and 2 and 3 m 27 is n	의	Gary E. Be		ather)		1					Maryland 21	
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat.		20a. Method of Disp 1 X Burial 2	osition			Place of Disposi crematory or oth	tion (Name of	cemeter	y,	Date	20c. Location - Cit	
Baltimore, bermit. Pages I an Department of Hee Important: If ite	L	-	Other Speci	fy:	Mea	adowridge				-	Elkridge, M	•
Balt permit. Depart Import	1	21. Signature of Fac	Peral Service Lic	ensee /	uM)		ame and Addr 14 Mounta			Gully-Pol Badena, M	yniak Funera aryland 2112	1 Home P.A. 2
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Examiner		Immediate Cause (For condition resulting	inal disease	Due to (or as a								Death
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ords * requi s been should	Completed									24a. Was autop		autopsy findings available to completion of cause of
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sion ttendin death. ctor: A y the fu	atio	1 Natural 2 ✓ Accident	5 Pending Investiga	Dec 24, 2	201.0°a"	0207 hrs	1	Yes 2	✓ No	Oriver of car	r that struck tree	
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be after the completely filled in by the funeral director, page 2 should be after the completely filled in by the funeral director, page 2 should be after the completely filled in by the funeral director, page 2 should be after the completely filled in by the funeral director, page 2 should be after the completely filled in by the funeral director, page 2 should be after the completely filled in by the funeral director.	린	3 Suicide	6 Could no determin	t De	of Injury - At he Roadway	ome, farm, street	, factory, office	e building		or Town, S	state)	Rural Route Number, City
bou hou y fill	1 2	4 Homicide 29a. Certifier 1 C	CertifyIng Physl			ge, death occurre	ed at the time,	date and			Tick Neck Road, F	
To the Howithin 24 h To the Fur		one) 2 🗸 N	Medical Examina	er: On the basis of and manner sta	examination a	nd/or investigation	on, in my opini	on, death	occurred at	the time, date	and place, and due to	the cause(s)
	= ²	9b. Signature and ti	ite of certifier	1			29c. Lice	nse numl C.M.E.	per		29d. Date signed () December 24,	
5° OCME	3	0. Name and addre	ss of person who	completed cause	of death (Item	23a)						
		Mary G. Ripp	1/	eputy Chief M			Penn Stree	et, Balt	imore, MD	21201		
Sta Registra	te ³ ar	1. Date filed (44 nth	29 2010	32. Reg	istrars Sanatu	barles						

10-10005 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Larry Wayne Beecher State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Month Day December 27, 2010 **Medical Examiner** Larry Wayne Beecher 0305 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** St. Joseph Medical Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** October 1947 oreign Portland, Country) Maine 215-46-5285 Hours Director 1 X M 2 F 63 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Lutherville Baltimore Maryland 1 Yes 2 X No mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.
portant: If item 27 is marked uther than "natural", nr items 23a nr 28a-f shou ury nr nther traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 224 Division Avenue 21093 of America Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married 2 XX No Yes 4 XXDivorced If Yes, Give Year Specify: white 3 Widowed 1 Yes 2 X No specify: <u>۾</u> 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Dept. of Utilities 12 1 supervisor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose V. Wilcox Lewis Wayne Beecher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17327 19a. Informant's Name/Relationship (Type, Print) 8236 Blooming Grove Road Glen Rock, Pennsylvania Terrie R. Beecher/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State December 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley 31, 2010 Timonium, Maryland 4 Donation 5 Other Specify: Memorial Gardens 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093

Approximate Internation 21. Signature of Funeral Service Licenses failure. List only one cause on each line. Methadone, Hydromorphone and Clonazepam Use

mediate Cause (Final disease a. Complicating Thermal Injuries Approximate Interval Physician Between Onset and /Medical Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a,pt.II,27,28a-f per me g912 2-9-11 vt X UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Vear Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Į 9 Unknown ned by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 ✔ Unknown Chronic Obstructive Pulmonary Disease Completed After this certificate has been 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? . death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director; 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Nursing Home 5 Residence 6 Other DOA 1 Yes No 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No Pending 12-27-10 12:00am subject in house fire 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 224 Division Ave. Lutherville, Md. 21093 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide residence determined (Specify) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedlcai Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b.-Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 27, 2010

DHMH 17 Rev 1/2001

OCME 2006

31. Date filed (Month, Day, Year, State Registrar

Zabiullah Ali, M.D.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death Baltimore V.A. Balti more Center medicaL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth NOV 23 9. Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** 1 ₹ M 2 □ F Hours Min. 217-16-8119 87 1923 Director Usual Residence of Decedent in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Baltimore Halethorpe 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 4506 Poplar Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Truck Driver Grocery Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Curtian Laura Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Linda Drive, Catonsville, MD 21228 Christine Wirth / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 01/03/2011 Crownsville, MD MD Vet. 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility MacNabb Funeral Home, Frederick Rd.. Catonsville. MD Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner mo Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in deeth). Due to for as a consequence of Examin and-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has this certificate 1 🗌 Yes 2 🗎 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 In No မ 1 Yes 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral Matural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifie

filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29

29d. Date signed (Month, Day, Year)

10 North Greene Street Baltimore, MD 21201

10-09997 Shirley Ann Crosby Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

rley Ann Crosby		State of Maryland / Departmer For State Certificate	it of Health and Mental H e of Death	iygiene Reg. No	2010 4	0950
Physician	Re	gistrar Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time	e of Death 45 hrs
Pnysician edical Examine		Shirley Ann Cr	osby	Month Day December 26,	2010 202 lc. County of Death	45 1118
	4	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat Catonsville		Baltimore County	
		3 Cedarwood Road			M/DD/YYYY) 9. Birthplace	(State or
Funeral		Social Security Number	Months Days Hours Min	_	Foreign W	est irginia
Director		236-66-4205 1□M 2▼F 66	113.	1100 203		
á u		Isual Residence of Decedent Oa. State 10b. County 10c. City, Town or	Location			reside City Limits Yes 2 X No
pro s		MD Baltimore	<u>Catonsville</u>	1400	itizen of What Country?	100 2 22,110
Maryland 28a-f show any d at once.	Director	Oe. Street and Number	10f. Zip Code	10g. C		
the Notified		3 Cedarwood Road	3. Was Decedent of Hispanic Origin?	Specify Yes or No-	USA 14. Race - American Inc	ian, Black,
h with	Funera	1. Marital Status Armed Forces?	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.	
or deat		1 Yes 2 Z	1 Yes 2 X No specify:		Specify: White	
irs afte	<u></u>	11 Johnson and completed) 162 De	ecedent's Usual Occupation (Give kind or pring most of working life. DO NOT use re		. Kind of Business/Industry	'
72 hou		Elementary/Secondary (0-12) College (1-4 or 5+)			Restaurant	
vithin ene.	Completed	10	stess / Owner	ne (First, Middle, Maide		
215-0036 be filed within 72 hours after death with the Maryland nal Hygone. riced other than "natural", or items 23a or 28a-f she cent, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last) Otmer Hardy Payne	Beulah	n Grac	ce Benne	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	e Be	10a Jafarmant's Nama/Relationship (Type Print) 19b.	Mailing Address (Street and Number o	r Rural Route Number,	, City or Town, State, Zip C	code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly, or items 23a or 28a-f shou injury or other traumatic event, the Medical Examiner must be notified at once.	7		1 S. Justison St.,	Apt. 517	Wilmington, lc. Location - City or Town,	DE 19801 State
e, P. I and Healt Fitem	ı	zoa. Meti lod di Dispositioni	Disposition (Name of cemetery, by or other place)			
Pages ent of nut: I		- Imetro	Crematory, Inc. 12		Baltimore, M	
mit. spartm	Ī	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee George MacNabh	299 Frederick Ro	Cremation S	more Maryla	nd 21228
	4	23a. Part I. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardia	c or respiratory arrest,	shock, or heart Apr	proximate Interval
Physician /Medical	1	failure. List only one cause on each line.				Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death) a. Typerterisive Attribusors at a consequence of):				
		Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):				
	Ē	cause. Enter Unuerlying Cause				
ıi ii	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
	dical	d. UNPENDED AMENDED				
e be er	ğ	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	Voor
1876 tificat ing ph as the	an/N	23b. Was decedent pregnant in the		gnancy	Month Day	Year
Box 68760 e death certificate b the attending physical ed for use as the bu	sicia	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
o. O. B. that the de ned by the detached f	Physician/Me	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		cco use contribute to the c	
cords, P.O. law requires that that be has been signed by e 2 should be detac		chronic alcoholism		_	2 No 3 Probably	
ds, require	etec			24a. Was an autopsy performe	prior to comp	letion of cause of
COI te law ge 2 st	Completed by			1 Yes 2	<u></u>	2 No
Vital Recysician: The l		25. Was case referred to medical	26.Place of Death (Ch		esidence 6 🗸 Other: Sce	
Vita vysicia	To Be	1 Yes 2 No	utpatient 3 DOA Oute 4 No Time of Injury 28c. Injury at Work?	28d. Describe hov		
Of ing Pl		(Month, Day, Year)	1 Yes 2 No	1		
SiOn trend death. ctor: y the f	Satio		arm, street, factory, office building, etc.	28f. Location (Stre	eet and Number or Rural F	Route Number, City
Division of Vital Records, tallor Attending Physician: The law requirers after death. Tal Director: After this certificate has been silled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Stat	te)	
Lospita 4 houn funcra		4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the cause(s) and manner as stated.	use(s)
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date an	29d. Date signed (Month,	Day, Year)
# 2 # 8	₹	29b. Signature and title of certifier	29c. License number O.C.M.E.		December 27, 2010	
		Therdore U. King JR, un	- O.O.IVI.E.			
+		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Exam	niner 111 Penn Street, Baltir	more, MD 21201		
J	_		parts.			
S Reais	tat	nec a giran h	Barres			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month S'30AM UN nance December Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Korea 216-25-8234 82 Months Davs Hours Min. (Month, Day, Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD Bladens Prince Georges 1 Yes 2 No bur G 10e. Street and Number 10g. Citizen of What Country? Funeral South 612 2071 C KOTEO EMERSON 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Specify: "natural" ASIAN Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other fraumatics. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) I ruck-DrivER Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BON han (Y N 0019b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2071 0 599 EMLISON ST. APT BOALENSOW C; MD 19a. Informant's Name/Relationship (Type, Print) Chuno-Nam Chang WITE 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State DOVIDSONVILLE, MD 12-29-2010 ake MT Memoriallam Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Howel WNRYO ar toRD 20794 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy page perform 2 🗆 No Yes 2 No 1 Yes Division of Vital funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at after death. Director; After t 28d. Describe how injury occurred Hospital or Attending work? 5 Pending injury 1 🔀 Natural Accident Investigation 3 Suicide 4 Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 26 MD 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI KUM State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 25,29c per me,g910,12/27/2010dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 10:10 PM Doce! Medical 2010 B Fadility Name (if not institution, give street and number WASHING AS MEDICA) **Examiner** City, Town, or Location of Death County of Deat If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Yea, Funeral 215-28-6299 1**X** M 2 □ F Months Days Hours Min. Director Yrs. 1932 Maryland Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🏋 No Maryland <u>Anne Arundel</u> Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 998 Oakdale Circle 21108 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ed Forces? Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Union Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kermit Crosby Delma Maryjane Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Crosby / Wife 998 Oakdale Circle, Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Borial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Denation 5 🖨 Other (Specify) Metro Crematory 12/10/2010 Catonsville, Maryland 21. Signatu Of Hum icensee Name and Address of Facility rkley-Ruddick 1 Crain Hwy. S Funeral Home, P.A. E: Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to or as a consequence of): MILIN APPRINED BY MEDICAL ENAMINES that the death certificate be executed 10 attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery page 2 should be detached for in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown the 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Director: After this certificate 2 No 1 🗌 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifies completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation M Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. 29c. License number D59919 30. Name and addre person who, completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signature State 9 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 010 3.45PM ECEMBE 22 Charles Hancock Calvert Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HMME ALTIMORE KARHINGTON MEDICAL uni)E If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🛭 M 2 🗆 F Months (Month, Day, 219-01-2201 **Director** 96 Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1821 Bayside Beach Road 21122 permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hyglene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Automotive Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Calvert Sr. Annie Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) しょういっと Thomas E. Calvert 1821 Bayside Beach Road, Pasadena, MD 21122 (nephew) Baltimore, Date 30 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 2010 21. Signature of uneral Sanic Lic 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ ADVANCED EMER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year the i signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d, Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3

24 hours after deat Funeral Director; within 2 To the F Eoo

Registrar

29b.

Signature and title of certific

address of person who co

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potented cause of death (Item 23a) Type, Print)

32. Registrar's

29c. License number

leu Burnie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mario Caruso 727 Leon 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Numbe 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Year) 20 **Funeral** Days 0 7 1 4 1 ★ M 2 □ F Months Hours Min. Director 90 149-03-8830 Usual Residence of Decedent or 28a-f show 10a. State 10c, City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shoi Director Highland 1 ☐ Yes 2 No MD Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20777 U.S.A. 65 Paper Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Atlantic Tool & Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Argia Fatticcione Melchiorre Caruso mol.,
it. Page 1 and 2 shour.
it of Health and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 Paper Place, Highland, Maryland Michael Caruso-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Immacylate Conception <u>12/30/2010</u> Montclair, 22. Name and Address of Facility
Megaro Memorial Home
503 Union ave, Belle 21. Signature of Femeral Service Licens Belleville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ anythmia disease or condition resulting in death) Medical Due to (or as a onsequence of): Examiner CAD Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for set a consequence of, A that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No To the Funeral Director; After this certifica completed filled in by the funeral director, I To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural death. 1 🗌 Yes 2 🗌 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 200 66511 Dec 25 2010 on 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane, Columbia,

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Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U | U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timore imonil 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) PETWICK, PA Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. Hours 1 □ M 2 🗹 F Days Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **N**o Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life_DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဥ 19a. Inform nt's Name/Relationship (Type, Print) acugnte. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Baltimore, 20a. Method of Dispos 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Forest Hill 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between oma Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner 990 bll Signature of the state of the s Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12-months? 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🌠 No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifig CRNP RO80210 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 32. Registrar's State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40956 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cheek,_Sr. 2010 02:45A M Medical <u>William</u> Dubois 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's <u>Southern Maryland Hospital</u> Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Day, Days Hours Min 1 X M 2 D F Months **Director** 242-46-3438 NC 1935 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2 □ No MD Prince George's District Heights ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 20747 USA Wintergreen Avenue death \ 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried þ ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced **Black** the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) D.C. Government Mental Health Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Grant Cheek Leona Waddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wintergreen Ave. District Heights, MD 20746 permit. Page 1 and 2 Department of Health Important: If item 23 any injury or other t Barbara C. Cheek/ Wife 2221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 12/29/2010 | Brentwood, MD 21. Si that ure of Funeral Service Lice 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COL disease or condition Medical resulting in death) e to (or as a consequence of) Examiner SPIRATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) attending physician for use as the hiria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctonic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) been signed by the sahould be detached to 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate has page 2 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Day, Year) DECEMBER 2010 death (Item 23a) (Type, Print) 20735 31. Date filed (Month, Day, Year) State 29 Registrar

DHMH 17 Rev 7/2009

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

Physician/Medical the attending p ed by the detached page 2 Be P Certification: s after death. spital

Physician

/Medical

Director

Funeral

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Completed

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r than "natural", or Items the Medical Examiner me

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Ite ury or other traumatic event, the Medical Examine.

Department o Important: If any Injury or once,

Physician

/Medical

ltimore, Maryland 21215-0036

with the Maryland

within 24 hours at To the Funeral C filled

				_ 1 🔼 Y	es 2□No 3□	☐ Probably 4 ☐ Unknown	
				24a. Was a autop perfor 1⊡ Yes	sy prio med? deat	re autopsy findings available r to completion of cause of th? Yes 2 1 No	
25. Was case referred to medical			eath (Check only or	(Check only one)			
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3 ☐ [Home 5□Resid	lome 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investiga		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred		
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		nome, farm, street, factorify)	28f. Location (S City or Tow	treet and Number on, State)	or Rural Route Number,		
29a. Certifier 1 Certifying	Physician: To the best of my kn	owledge, death occurre	ed at the time, date and pl	ace, and due to the	cause(s) and mann	er as stated.	

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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MD 21201

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St # N EUTAW 308 BALLIMORE

31. Date filed (Month, Day, Year)

9

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛴 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 2010 Physician/ Randy W. Dell 8:24 A M 29 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min 8-13-1951 MD Country 216-56-6681 59 Director Usual Residence of Deceden 28a-f show 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director Carroll MD Finksburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2613 Sandymount Rd. 21048 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing 12 Salesman and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Woodrow Wilson Dell Clara H. Green permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Dell-wife 2613 Sandymount Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 12-31-10 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. 21. Signature Fuyeral Service Licens 22. Name and Address of Facility Fletcher Funeral Home homas 7 Main St. Westminster, MD 254 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to forms monsequence offr cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year Pregnant
Unknown 1 Yes 2 9 Unknown ed by the a 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 🛛 Probably 4 ☐ Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an After this certificate has funeral director, page 2 performed? Yes 2 X N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) 1 🗌 Yes 2**X** No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred House 5 Pending Natural Accident 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signatur€ 29c. License number 29d. Date signed (Month, Day, Year) D0067468 12/29/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER, MD 21157 555 South Center Street Mohit NArang 31. Date filed (Month, Day, Year,

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 19³ 2010 6:30 рм John Richard Davis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Homewood Center Baltimore 6. Sex 1 ♣ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min Director 214-38-1580 Yrs. Maryland July Usual Residence of Decedent or 28a-f shov 10b. County 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 524 N. Charles Street Apt. 1518 21201 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner "natural", or b 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes 2 ☐ No Specify. 3 → Widowed 4 □ Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Photographer Photography Studio Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Davis Gwendolyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5229 St. Charles Avenue Baltimore, Maryland 21215 Malcolm Davis - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/3/2011 Greenmount Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Chatman—Harris Funeral Home
5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. I st only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e 2 performed 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ပ္ 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending nours after death.

neral Director: Aft
filled in by the fur 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours at

To the Funeral D

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

man woods

ompleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANTE D М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 F Months Days Hours Jun 27, Director 221-34-1463 1950 Colorado 60 Usual Residence of Decedent or 28a-f show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Anne Arundel Severna Park 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 143 Boone Trail 21146 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **5+** School Principal Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I rtant: If item 27 is marked o David Hamlin Jane Arthur Etheridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Daniel/Husband 143 Boone Trail Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/28/10 Woodbine, MD 21. Signa of Funeral Service Lie 22. Name and Address of Facility Ging Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months Day Year Pregnant at time of death ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed icate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate | 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 은 1 🗌 Yes After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred HOUSE (Month, Day, Year, 1 Natural 5 Pending within 24 hours area acc.
To the Funeral Director, Aft 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie lau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FENSE HWY, ANNAPOLIS, M.D. 21401 IGHTFOOT-MENIEVE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancy 2010 Duncan December 12:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holly Hill Nursing Home Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗶 F Hours Min. NOV 1, 1934 Mary land Director 76 218-30-5207 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MDBaltimore Dundalk 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 2502 Ambler Court 21222 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian O. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No 1 ☐ Yes 2 ☐XNo Specify: Specify: White "natural" Completed 3 Widowed 4 X Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic manner. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Insurance Adjuster Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William T. Franks Euphemia A. Burdette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra A. Lohrmann/daughter 2502 Ambler Court Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/28/10 Woodbine, MD Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD le. MD 21029 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line. isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 1 HROMBOSIS Ph_{siin} disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of Exami the bunal-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? perform 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be

or Attending Physician: The law requires that the death certificate be executed Records,

within 72 hours after death

Maryland 21215-0036

Baltimore,

attending signed by the a

Medical

Certificate:

Division of Vital To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir

> State Registrar

ASNEEM 31. Date filed (Month, Day, Year)

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29b. Signature and title of certifier

4 Homicide

only one)

29a. Certifier (Check

determined

2835 "HATTI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20595

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Ann Donithan Pм 5:46 December 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center For Hospice Towson Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Jan. 18, 1953 Director 212 62 6706 57 Maryland Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Baltimore Middle River 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 723 Seneca Park Rd. 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business Industry Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Lawn & Garden 12 ith and Mental Hygie 27 is marked other r traumatic event, ti Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even မ Gertrude Maddox James Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Donithan Jr. (Husband) 723 Seneca Park Rd. Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Ebenezer Church Cemetery 12/31/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ^{22. Name and Address, of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Opset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use, contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 No 1 Yes Yes 2 Division of Vital Be 25. Was case referred/to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

DEC 292010

A April S Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24,2010 Physician/ Karen Leslie Downey December 10:57A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Months Hours (Month. Baltimore, MD 218-44-3103 **Director** 64 Aug. 10, 1945 Usual Residence of Decedent il Hygiene. I other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Baltimore County Timonium 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 221 Solway Road 21093 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) 04 Elementary/Seconday (0-12) Service Representative Verizon Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Harry Hobart Downey Charlotte Lillian Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Ms.Amy C. Crowe 7716 Shirley Ave. Pasadena, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel and Cremation Services, Inc. 20a. Method of Disposition 20c. Location - City or Town, State (Harford County) Forest Hill, Maryland Date 1 Burial 2 Cremation 3 Removal from State Tuesday 4 ☐ Donation 5 ☐ Other (Specify) Dec.28,2010 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Peaceful Alternatives Funeral and Cremation Center, P.A. Lic.#M00677 21093-2215 2325 York Road Timonium, Maryland 23a. PM 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Due to (or as a consequence 1): Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** MONACI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month ☐ Pregnant at time of death ☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ပ္ 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral Certificate: 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medica 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of d tem 23a) (Type, Print) ath ラ V 21204

State Registrar 31. Date filed (Month, Day, Year) _

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 413 AM Barbara S. Dripps Pece Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 69 June 17, 1941 New York **Director** 059-34-1268 Usual Residence of Decedent fshov 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1439 Valbrook Court South 21015 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ģ 1 Never Married 2 X Married Yes 2 No Mental Hygiene. narked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Assistant Branch Manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Arthur Brandt Solveig Gulbrandsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert G. Dripps / Husband 1416 Kahoe Road Forest Hill, Maryland 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Dec. 28 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel Rel Air 2010 Forest Hill, Maryland 21. Signatu / Funeral Service Licenșee 22. Name and Address of Facility
Evans Funeral Chapel
3 Newport Drive Fore pel & Cremation Service—Bel Air prest Hill, Maryland 20050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final) Onset and Death ₹nysician/ disease or condition resulting in death) Medical Due to (or as a correquence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Hospital or Attending Physician: The law requires that the take hours after death.
24 hours after death.
25 Hours after death.
26 Hours after death.
27 Hours after death.
28 Hours after this certificate has been signed by the target filed in by the funeral director, page 2 should be detached. PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No Yes Vital 25. Was case referred to medica 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **2** No |요 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 68 person who completed cause of death (Item 23a) (Type, Print) Ches apacke Drive AN Inon

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed //

Yea 9

2010

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lawrence Medical December 2010 :29 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Days Hours Min Director 219-50-7469 Country) 61 9 1949 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County should be filed within 72 hours after death with the Maryland Director 10c, City, Town or Location 10d. Inside City Limits MAryland Baltimore 1 🗆 Yes 2 🖵 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2117 Westchester Ave. 21228 United States "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. 3 Widowed 4 Divorced Specify: White other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Financial 4+ <u>Ac</u>countant Be .. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked otl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Junior Martin Evans Kathryn Maureen Copeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Evans / Wife 2117 Westchester Ave., Baltimore, Maryland, 21228 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: If any injury or Atlantic Crematory 12/27/2010 | Glen Burnie, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home, In 21. Signature of Funeral Service Licenses 7250 Washington Blvd., Elkridge, Maryland 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final d hysiciani Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown Month Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation after death filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29c. License numbe 29d. Date signed (Month, Day, Year) MD 71040

Registrar
DHMH 17 Rev 7/2009

State

701

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST

82 Registrar's Signature

NCHAPLES

State of Maryland / Department of Health and Mental Hygiene U | U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>5,2010</u> Physician/ NANCY JEAN ENGELHARDT A^{M} December 5:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Balt<u>imore Medical</u> Center Towson
If Under 1 Year If Under 24 Hrs. timore 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Months Days 1 □ M 2 🛛 F Hours July 5 Maryland 217-46-1310 68 **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 113 Lake Avenue 21210 USA ENGELHARDT, NANC Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) altimore, Maryland 2121 and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Registrar of Admissions College Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Alvin Engelhardt Dorothy Ellen Hitchcock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Richard A. Engelhardt (Father) 113 Lake Avenue, Baltimore, Maryland 21210 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Dul Valley Mem Grdns 12/29/2010 Timonium, Maryland 21. Signatur Africa S. J. Light Martin D. Lawson ²MITCHELL WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumania disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as the IF FEMALE: nse s 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death for in the past 12 months? Month Year Pregnant at time of death signed by the a 2 🗆 No g | Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Tes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 044 32. Registrar's Agnature, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtIc., 25 per me, 910, 12/28/2010dhb

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Easton Dece Roland 2010 11 29 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltinure B Hospital altimore Servo ws 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 D F Months 220-64-2828 Davs Hours Min. 02/26/1954 Country) 56 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 21223 10g. Citizen of What Country? Funeral 1705 Wilkens Ave. USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No 1 X Never Married 2 Married Black, White, etc. δ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give White Specify 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Self-employed 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Weddington Melva Easton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7620 Ashton Valley Way, Catonsville, MD 21228 19a. Informant's Name/Relationship (Type, Print) Donna Decker / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State cedar Hill Cemetery 12/13/2010 Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Septice Licensee 22. Name and Address of Facility Home and Cremation Service, PA Rl G M01452 3 Annapolis Rd., Halethorpe, MD 212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) anoxiL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine d any, leading to immediate cause. Enter Underlying Cause (Disease or injury Chronic Narcotic Abuse ON APPROVED BY MEDICAL EXMIN burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Yes 2 Dunknown Unknown To the Hospital or Attending Physician: The law requires that the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ Division of Vital Records. 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) niner? 1 X Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral prices. 1**≥**≪latural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 66108 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Simmons 2000 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24, Irma Maritza Euceda December 2010 1622 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) Dec 23, 1 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Hours Min. Country) Honduras Director 602-18-9971 Yrs 1956 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits MD Montgomery Silver Spring 1 ☐ Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 916 Daleview Dr. 20901 Honduras 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ò ð 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 🖔 Yes 2 □ No Specify: Hondurean "natural", 3 Widowed 4 Divorced Specify. White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done (life, DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Certified Public Accountant Accounting/ Finance Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic event,
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Conception Munoz Irma Consuelo Gamez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joel Euc</u>eda / Husband 916 Daleview Dr., Silver Spring, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Chesapeake Crematory: 12/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD ²² Name and Address of Eacility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD of Funeral Service Almenn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pulmonary Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo 3 Ctopic pregnancy
5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 Se No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 XNo Other: 1 Yes Certificate: To 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 🕍 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 🗌 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 1 XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D5846 12 24 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 1500 Forest Glen Rd., Silver Spring, MD Carolyn Sporn M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eisenhera Hannah 5:30 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MO Baltimore Baltimore 2 HIGHSTEPPER COURT, #201 Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 1 M 2 Director 218-07-7443 95 08 01 Usual Residence of Decedent or 28a-f show notified at I and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 2 HIGHSTEPPER COURT, #201 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify WHITE Specify. 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) PHARMACIST PHARMACY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EUZENT MINNIE GOLDMAN MORRIS or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HIGHSTEPPER COURT, #201, BALTIMORE, MD LOUIS EISENBERG/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) HEBREW YOUNG MEN CEM: 12/29/2010 BALTIMORE, MD ature of Funeral Service Lige see 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death heart failurg Ph sician/ congestive Medical resulting in death) Due to (or as a con equence of) Examiner aorno stenosis Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying dilease coronon artin Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one. Be examiner? Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 28b. Time of 28c. Injury at After 5 Pending **Natural** 1 Natural 2 Accident 1 🗆 Yes 2 🗆 No within 24 hours after death To the Funeral Director: A Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu**/**e and title of cer 29c. License number 29d. Date signed (Month, 100630 2010 M

Registrar

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State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LYTE

31. Date filed (Month, Day, Year)

MICITE CION

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Samella Edwards 10, 4:30 P M December 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Monygomery Holy Cross Hospital 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MS **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min 425-36-5919 87 Yrs Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f Silver Spring MD Montgomery 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a 901 Arcola Avenue 20902 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🖵 No filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced "natural" Completed Black Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Campbell Soup Co. Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Gore Sallie Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 3280 Karen Drive Chesapeake Beach, MD 20732 Louis Edwards 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 12-21-10 Columbus, MS 4 Denation 5 Other (Specify) Union Cemetery 21. Signa Tre of Juneral Service Lice 22. Name and Address of Facility Grace Funeral Home 607 North Conduit Blvd., Brooklyn, NY 11208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Aspiration Pneumonia Medical Due to (or as a consequence of) **Examiner** Diabetic Ketoacidosis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit Cause (Disease or iinjury Sepsis that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Severe Protein Malnutrition Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's Disease, Dementia, Anasarca Division of Vital Records, 1 ☐ Yes 2 ♠No 3 ☐ Probably 4 ☐ Unknown MRSA Infected Pressure Ulcers 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the lirector, page 2 s autopsy performed? 1 ☐ Yes 2 🗷 No Yes 2 AND a er death.

Director After this certific
In by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🖾 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral D

completed filled Hospital Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficiency representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Suparrich D 0065485 RSM MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD Barbara Supanich, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

X DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month tergusor 2:50 PM 19 POIOS Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Hospital Samaritan Good NIA Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Min Hours 90 Director Yrs Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location with the Maryland is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director TOWSON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Raven Boulevard USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Black 3 Widowed 4 ☐ Divorced Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) 2-th (Nade life. DO NOT use retired) College (1-4 or 5+) Seamstress Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ ester Clark Ellen Bentor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Fannie Smith Paven Bowlevard #310 Towson, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 1 M Burial 2 Cremation 3 Removal from State CH saltimine, MD 4 ☐ Donation 5 ☐ Other (Specify) vbutras erreten Signature of Funeral Service Licensee Vallann C. Greene Plineral services 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Se disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner # Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ned by the atten in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy hours after death. Ineral Director: After this certificate 2 No 1 Yes 2 No Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 2 No Certificate: To 1 12 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) yardan MD REJ 000 12,23,2010 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) V Raven Blr. Yazdany 5601 Bathmore, MD, 21239 Loch State Registrar

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after deat Funeral Director; the

altimore, Maryland 21215-0036

State Registrar DHMH 17 Rev 1/2001

Medical

completely

and manner stated

ORIGINAL

29d. Date signed (Month, Day, Year)

1 Neertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MD

N. EUTAW ST Sinte 308 Balhmore MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 HASKMI MD

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BARBARA FOREMAN 7:15 AM 25 Medical 12 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE MEUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Months Days Hours March I5. Country) 277-42-7542 Director 65 1945 Ohio Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct 1 ☐ Yes 2X No Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a ed other than "natural", or items 23: event, the Medical Examiner must 210 Penderbrooke Court 21032 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give 3X Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Transcriptionist Pathology Laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ other traumatic Arthur Frederick Tallon ige 1 and 2 should be nt of Health and Mere: If item 27 is mark Anne Marie Bacci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caryl T. Tallon/Sister 1210 Penderbrooke Court, Crownsville, MD 21032 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter, crematory or other place)
West Arundel Crematory permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State injury or December 28, 4 Donation 5 Other (Specify) 2010 Odenton, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 any Will Er Bour M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death ₽hysician: CANCER disease or condition resulting in death) LUNG Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the burial-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte Day ☐ Pregnant at time of death ☐ Unknown Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician; The law requires 3 Probably 4 □ Unknown OBSTRUCTIVE PULMONARY Completed 1 Yes 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No After this certificate 1 🗌 Yes 2 🗆 No 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🔾 0 Other: မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury after death. Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral I Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 6675 30. Name and address of p completed gause of death (Item 23a) (Type, Print) 2001 Capstack Medical M. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ Godfrey Archie Foster 2010 8:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 10000 Brunswick Ave. 6. Sex 1 **X** M 2 □ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 3/9/1945 Director 579-56-0925 65 DC Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10000 Brunswick Ave. #504 20910 United States items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. or 1 Never Married 2 XMarried ģ ☐ Yes Yes, Give 2**XX**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural" 3 Widowed 4 Divorced Black Completed Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement 11 Contractor Be should be filed 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed thent of Health and Mental Hitant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Emma Maelee Godfrey John L. Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carita M. Foster / Wife 10000 Brunswick Ave. #504, Silver Spring MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory 12/29/2010 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligense Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Brain Metastases disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Small Cell Lung Cancer Sequentially list conditions, if any loading to increase Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury and -transit Exami that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Se l or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 V Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes 2V VNC Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🗶 Natural 5 Pending death. 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Hospital within 24 hor To the Fune completed fi

> State Registrar

Lester Miles M.D., 1160 Varner St. NE, Washington D.C. 32. Registrar's Signature DEC 29 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

29c. License number

D0026024

December 28, 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of State of Registrer	of Maryland		artment of I		nd Mental Hy	giene) Reg. No.	010	.09	76	
	Dhuaisi		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of D	Death	
	Physici /Medic		Alice Giroux					Decemb	, _		9:47A	M	
	Examin		4a. Facility Name (If not institution, give street and nu			4b. City, Town, o	or Location of	Death	4c. Co	ounty of Death			
			South River Nursing & Re				water	4 Hrs. I a min (Pi		nne Arı			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last 91	Yrs.	If Under 1 Year Months Days	Hours 2	Min. 8. Date of Bir (Month, Date of 14	th iy, Year)	9. Birth	place (State or intry) Hampsh	Foreign	
	Director		Usual Residence of Decedent	91				Dec 14	, 191	9 New	nampsn.	ire_	
	land ow		10a. State 10b. County	10c. City, T	own or Lo	ocation					10d. Inside City	Limits	
	Mary -f sh	to	Maryland Anne Arundel		ç	Severn					1 ☐ Yes 2	2⊠No	
	r 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Cou	intry?		
	h with		1352 Brenda Road			21	144		Uni	ted Sta	ates		
	deat	ner	11. Marital Status 12. Was Dec	edent Ever in U.S.	13.	Was Decedent of I	Hispanic Orig	in? (Specify Yes or No Puerto Rican, etc.))- 14	Race - Amer Black, White			
ဖွ	after or ite	F	1 Never Married 2 Married 1 Yes, G	2 X No		1 ☐ Yes 21② No		T donto I madri, oto.)		necify:			
993	ural',	d b	3 🔀 Widowed 4 🗌 Divorced Year or [Dates:						V	White		
5-	"nati	lete	15. Decedent's Education (Specify only highest grade completed,		(Give	dent's Usual Occu _l kind of work done DO NOT use retire	during most	of working	16b. Kind	d of Business/li	ndustry		
12	withir ane. than	e Completed by Funeral Director	Elementary/Secondary (0-12) College (Goggle Company								
	filed Hygid ther		17. Father's Name (First, Middle, Last) (unk)	<u> </u>	GOGG	le Maker	18. Mother	's Name (First, Middle		-	ink)		
an	d be antal red o	o Be	(am)							, (0	шист		
Z	Shoul nd Me mark mati	2	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street	and Number	or Rural Route Numb	er, City or 1	Town, State, Z	ip Code)		
S	ith ar		Ronald Giroux/grandson		1352	Brenda	Road	Severn, Ma	rvlan	d 21144	1		
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examinet could be notified at ODGs.		20a. Method of Disposition	20b. Place		osition (Name of matory or other pla		Date	-	ation - City or T		100	
E	Page ent o nt: If ry or		1 ☐ Burial 2 【Cremation 3 ☐ Removal from '4 ☐ Donation 5 ☐ Other (Specify)	State			1	12/27/2010	Woo	dhine	Marylar	br	
alti	mit. partir porta / inju		21. Signature of Funeral Service Licensee					ation Serv				101	
m	Depa Impo		Quanta R Thomas	M0095	57 E	everly L	. Heck	rotte, P.A	. Cla	rksvil	le, MD 2	21029	
			23a. Part1 Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. [Do not ent	er the mode of dy	ng, such as c	ardiac or respiratory a	rrest,		Approximate Interval Betw	/een	
of Vital Records, P.O. Box 68760,	Physician		Immediate Cause (Final disease or condition resulting in death) A Spivation Prelimonia Due to (or as a consequence of):									eath	
	/Medical												
	Examiner		Sequentially list conditions, b.										
	sit sit	Examiner	cause. Enter Underlying										
	and I-tran	каш	Cause (Disease or injury that initiated events c. Pue to	(or as a consequen	ce of):								
60,	ate be executed physician and the burial-transit	ical E	545.5	(or as a obrisoquori	00 01).								
387	icate phys s the		d			-							
9 X	death certific e attending pl ed for use as t	Physiclan/Med	IF FEMALE: 23c. If yes, or		23	d. Date of deli-	verv						
B	atter after I for u	clar	in the past 12 menths?	birth 2 □ Fetal de nant at time of death		□Ectopic pregnand □ Other (s <i>pecify)</i> _	У			Month	-	ear	
o.		ysi	9 ☐ Unknown 9☐ Unkr										
	uires that signed b d be deta	To Be Completed by	Part II. Other significant conditions contributing to	23e. Did	tobacco use	use contribute to the cause of death?							
rgs	w requires been sign should be		Acute Renal A	1 🗆	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown								
00	aw requ s been 2 shouk		Hyper-Notrem	f cn.					24a. Was an autopsy finding prior to completion			vailable	
Re	The lav			mentic	,			perfe	ormed?	death?	2□ No	use or	
ita			25. Was case referred to medical	7776	·		26. Place	of Death (Check only	12.00 22.00				
of Vital Records, P.O	Physician: r this certific ral director,		examiner? 1 ☐ Yes 2 ② No Hospital: 1 ☐	sing Home 5 Res	Home 5 ☐ Residence 6 ☐ Other (Specify)								
	tending Physician: leath. tor: After this certific the funeral director,		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Moi	28d. Describe	28d. Describe how injury occurred								
Sio	endin sath. or: A he fu	atle	2 Accident investigation			M 1]Yes 2□N						
Ž	or Att	Certification:	determined 200. Flag	e of Injury - At home ling, etc. (Specify)	, farm, st	reet, factory, office			(Street and i wn, State)	Number or Ru	ral Route Numb	er,	
	urs al eral D												
	Hosp 24 ho Fune felly fi	edical	29a. Certifier (Check only one) Certifying Physicien: To the land main and										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Mec	29b. Signature and title of certifier			29c. Licen	se number		29d. Date	signed (Month	n, Day, Year)		
	⊢ 3 ⊢ ŏ			urana		2 5	5065	3	12	. 22	-2010)	
			30. Name and address of person who completed cau		Ba) (Type.	Print)	van,	. C . Sun	217-111	A			
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	Registr	ar	BEC 2 9 2010 CENTRAL) L. 1									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 45 M 2010 W Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltomore 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 №M 2 🗆 F (Month, Day, Year) 07/24/1973 173-64-4358 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Harford Bel Air 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 802 Coconut Ct., Apt. C 21014 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical gonce. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Not Employed Not Working Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Goltz Linda Conrad 19a. Informant's Name/Relationship (Type, Print)
Linda Goltz / Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Pine Ct., Cresson, PA 16630 20a. Method of Disposition
1

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/30/2010 St. Francis Xavier Cem. Cresson, PA 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility. Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 Mhl E. R. M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lications of End Stage Liver Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for sels consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant 9 Unknown Day Year Pregnant at time of death 5 Other (specify) Yes 2 ☐ No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P25678 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Guen N. Lacerda, MD, University of Maryland Medical Center,

Baltomore, MD, 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical or Location of Death ounty of Death **Examiner** ionsville Noss NON 9. Birthplace (State or Foreig If Under 1 Year If Under 24 Hrs. 6. Date of Birth 7. Age (In yrs. last birthday) Funeral (Month, Day, Ye Min. Country) 1 M 2 F S Utah Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County 10a. State should be filed within 72 hours after death with the Maryland and Mental Hyglene. It is marked that than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at aumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Hyattsville Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20783 2006 Wooded Way . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 2 No δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: If Yes, Give White Year or Dates. WW II 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland State Gov't. Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Parks/Planning Civil Engineer other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander ည (Unknown) Giauque (Unknown) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any july or other traumatic ones. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11700 Old Columbia Pike, Silver Spring, MD Douglas W. Giauque / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 XXCremation 3 ☐ Removal from State Chesapeake Crematory 12/29/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service Licenses Gist Ave.. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE RENAL DISEAS S Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Due to for selection exquence of, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) for been signed by the should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has performe 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical funeral director, examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 Yes 2 No s after death.

I Director: Af
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specity) determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene 20 0 9 7 9

. doquale Glergiii		1- For State Registrar	-	eate of Death	7.5	∠ U I C teg. No.	4031:			
Physician	n/	Decedent's Name (First, Middle, Last) Pasquale	2. Date of Dea	ath	3. Time of Death					
THE TANK	G	4a. Facility Name (if not institution, give street a	Giorgil]	4b. City, Town, or Location		Day Year er 23, 2010	1505 hrs			
		1012 Fawn Street		Baltimore		171				
Funeral Director		5. Social Security Number 220-68-3427 6. Sex	7. Age (In yrs. last bir	thday) If Under 1 Year If Un Months Days Hou		rth(MM/DD/YYYY) 9. Bir 7 , 1957 Foreig				
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town				10d. Inside City Limits			
land f show	ō	Md. N/A		Baltimore			1 X Yes 2 No			
3 C. Lin the Mary 23a or 28a-	Il Director	10e. Street and Number 1018 Fawn Street		10f. Zip Code 21202		10g. Citizen of What Cour USA	ntry?			
	by Funeral	1 Never Married 2 X Married Am	s Decedent Ever in U.S. ned Forces? Yes 2 No	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 Yes 2 No specify	n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
036 tthin 72 hours ne. r than "natur fedical Exami	Completed	15. Decedent's Education (Specify only higher Elementary/Secondary (0-12) Colle 12 years	Decedent's Usual Occupation (Give during most of working life. DO NO Longshorema	T use retired)	16b. Kind of Business/Industry Local 333					
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Constandino Giorgi			er's Name (First, Middle, I Josephine F	laterote	= 			
MD 27 nd 2 should alth and Me m 27 is ms		19a. Informant's Name/Relationship (Type, Prin Terry Lee Reed	Wife	b. Mailing Address (Street and Nu 1018 Fawn Stree	et, Baltimor	re, Md. 2120	2			
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: Witem 27 is injury or other traumatic		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other Specify:	val from State cremat	of Disposition (Name of cemetery, ory or other place) Redeemer Cem.	December 30, 2010		, Maryland			
Ball permit Depart Impor	1	11. Signature of Funeral Service Licensee	nol Our	22. Name and Address of Facil Connelly Fund 7110 Sollers	ral Home Of	Dundalk, P	.A.			
Physician /Medical		23a. Part I. Enter the disease, or complications to failure. List only one cause on each line. Immediate Cause (Final disease a. A1	hat caused the death. Do not cohol Intoxic	ot enter the mode of dying, such as	cardiac or respiratory am	est, shock, or heart	Approximate Interval Between Onset and Death			
Examiner		or condition resulting in death) Due to (o	r as a consequence of):	3001011						
d		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
uted id ransit		events resulting in death) Last Due to (o. d.	as a consequence of);							
60, sate be executed by sician and ne burial - transit		X UNPENDED AMEND	_{DED} 23a,27,28a	-f per me g911	l-24-11 vt					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transicial Certification: To Be Completed by Dhysician Madical Expedical		3b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy ive birth 2 Pregnant at time of death 5 Unknown		ic pregnancy	23d. Date of delivery Month D	ay Year			
P.O. I that the med by the detached		Part II. Other significant conditions contribut	ing to death but not resulting	g in the underlying cause given in P		bbacco use contribute to t				
ds, Fequires een sign and be					24a. Was a		ably 4 ✓ Unknown opsy findings available			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact briffication: To Re Commission by Description:		25. Was case referred to medical		00 Place of Doub	1 ✓ Yes	sy prior to co med? death?	ompletion of cause of			
Vital F yssician: his certifi director,	ă	examiner? 1 Yes 2 No	Inpatient 2 ER/Ou	utpatient 3 DOA Other	(Check only one) Nursing Home 5	Residence 6 🗸 Other:	Scene			
ting Ph	- 17	7. Manner of Death	Date of Injury 28b. 1 Month, Day, Year)	Time of Injury 28c. Injury at Wor		now injury occurred				
Sior Attend death. ector: by the f	3	2 Accident Investigation	12-23-10 fd		could i	not be deter				
Division o spital or Attending sours after death, neral Director: Aft filled in by the fune		Suicide 4 Homicide Could not be determined Specify residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence 28f. Location (Street and Number or Rural Route Number, Control of Town, State) 1012 Fawn St. Baltimore, Md. 21202								
To the Hosp within 24 hos To the Fune completely fi		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
* F*F° 3	2	9b. Signature and title of certifier	\mathcal{A}	29c. License number		29d. Date signed (Mon				
	5	0. Name and address of person who completed	cause of death (Item 23a)	O.C.M.E.		December 24, 20	10			
Ø.V		Zabiullah Ali, M.D. Assistant Me	edical Examiner 11	1 Penn Street, Baltimore,	MD 21201					
Stat Registra	-	1. Date filed (<i>Month, Day</i> , Year) 3.	2. Registrar's Signature	harles						
DHMH 17 Rev 1/2001 OCME 2006	1			OCME						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 100M Medical 4a. Facility Name (if not institution, give street and number) 45. City, Town, or Location of Death Examiner benera D 02 MOLA If Under 24 Hrs **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 □ F Months Davs Hours Min 0771671916 Director 201-09-5157 94 PA Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 Ty No MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6336 CEDAR LANE, #102A 21044 USA or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 than "natural", 1 ☐ Yes 2 X No 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed withi f Health and Mental Hygien item 27 is marked other th 12 SALES **NEWSPAPER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GREENBERG BUBBIE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HERBERT GREENBERG/SON 11168 OAKENSHIELD CIRCLE, COLUMBIA, MD Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Page 1 Date 1 \square Burial 2 K Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) HILLTOP SERVICE CORP! 12/28/2010 TOWSON, MD Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequ Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irector, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 힏 2 No Other 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be after deat Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifi 29c. License number 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 24, 2010 Joseph Richard Goodwill 9:46 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2001 Garden Drive Forest Hill Harford Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 XXM 2 □ F Mary Land Director 215-24-8753 81 Aug. Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Maryland Harford 1 Tes 2 X No Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 2001 Garden Drive 20150 United States 12. Was Decedent Ever in U.S.
Armed Forces? 1947
1 X Yes 2 No 1951 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, any injury or other traumatic event, the Medical Examiner Completed by 1 Never Married 2 X Married X Yes Yes, Give be filed within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11 Maintenance Essex Community College Be Maryland Page 1 and 2 should be filed ment of Health and Mental Hy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Goodwill Merry (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Garden Drive Forest Hill, Maryland 21050 Mrs. Adelaide Goodwill / Wife Baltimore, Date 27, 2010 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ewans Funeral Chapel & Cremation Services—Bel Air 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. inomo disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Su uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 🚾 Probably 4 ☐ Unknown lipidema 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' eral Director: After this certificate I filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**XX** No 은 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Joseph

Plumtree

Road Sufe 102 Bel Air, Maryland

21015

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

104

32. Registrar's

Knight

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month nerman Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Timese 6. Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral If Under 24 Hrs. 1 №M 2 🗆 F Hours Min. **Director** MI Usual Residence of Decedent 10a. State 10b. County with the Maryland ms 23a or 28a-f sho must be notified at Director 10c. City, Town or Location 10d. Inside City Limits none 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 712 permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. ö 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 Specify: 6 aC 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced "natural" Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO;NOT use retired): marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 05171 101 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည traumatic 19a. Informant's Name/Relationship (Type, Print) and . of Health an. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilton Kd to More arbara +01 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō cemetery, crematory or other place ō Surial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Mills 4 ☐ Donation 5 ☐ Other (Specify) 1-07es Si vature of Funeral Service Licensee 22. Name and Address of Facility d23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ inges tive Medical r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day ate has been signed by the a page 2 should be detached f Yes 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, ascinima 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic autopsy performed Yes 2 W No Director: After this certificate 1 🗌 Yes Division of Vital Hospital or Attending Physician: filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 👿 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending work? 1 □ Yes 2 □ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland Raven Loch 31. Date filed (Month, Day, Year)

NFC 2 9 2010 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ N CEMBOR 21 00 2010 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 40W Date of Birth (Month, Day, Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State Director 1 Yes 2 🗌 No 10e. Street and Number 10g. Citizen of What Country? Funeral USA Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes. Give Specify. 3 Widowed 4 □ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Functal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition metastatic VULVEY CANCEL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 **V** No 3 Probably 4 Unknown Completed should ! After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy perform death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ျ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and itle of 29d. Date signed (Month, Day, Year) 73 d cause of death (Item 23a) (Type, Print) 30. Name and addre ompl

Registrar

DHMH 17 Rev 7/2009

State

MD

32. Registrar's Signature

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51.

Place

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40984 State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December Frank Hirst 9:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery 700 Kent Street . Social Security Number 8. Date of Birth (Month, Day, Y Apr 8, 1 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2 □ F Min. Hours Country Director 001-18-1024 1921 New Hampshire Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct MD Montgomery Rockville 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 Kent Street 20850 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify Specify: White Completed 3 🛮 Widowed 4 🗆 Divorced WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Meaone. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Marketing Researcher Kimberly Clark Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Hirst Lillian Ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Hirst/daughter 700 Kent Street Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Final Journey Crematory 12/29/10 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251Beverly L Heckrotte, P.A Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, Pancreatic Cancer disease or condition years Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending phy IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Uve Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 XN Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital Other: 4 Nursing Home 5X Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 1 Yes 2 No M Accident Investigation the 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by determined Hospital Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 27, 2010 D43083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George A. Sotos, M.D. 9707 Medical Center Dr. #300 Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene per me, g910, 12/27/2010dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Beverly A. Hallman December 2010 11:45 PM Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year) November 5, 1928 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Days Months Hours Min. Pennsylvania 208-22-0249 Director 82 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Montgomery Rockville 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 615 Denham Road 20851 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Forr Bessie Lantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13807 Parkland Drive, Rockville, Maryland 20853 Nancy Hansen/Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 14. 1 🗆 Burial 2 ី Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. 2010 Bethesda, Maryland 21. Signature of Funeral Service Livensee 22 Name and Address of Facility Robert A. PumphreyFuneral Home/Rockville, Inc. 300 West Montgomery Avenue,Rockville, Maryland 20850—2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vascular cerebral Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner estive ailuru neart cona sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): DICAL EXAMINER Exami tibrillation CERTIFICATION APPROVED and that initiated events Due to (or as a consequence of): resulting in death) Last the burialphysician failurt Physician/Medical renal Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hematoma (01d) Completed 1 Tes 2 💆 No 3 🗆 Probably 4 🗆 Unknown page 2 should e Hasions pleural 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 躇 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Set trying hystocham to the basis of examination and/or investigation, in my opinion, death pace and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signatyre and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO06 9336 December 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janelle Williams, MD 9901 Medical center Drive, Rockville, Mary/and 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 29 2010 park Registrar

2010

10

DECEMBER

HALLMAN

ANN

EVERLY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh 2910 12-29-10 vt

State of Maryland / Department of Health and Mental Hygiene | | | 40986 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day MPHREY **Physician** 12 ME 2010 ember /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year sanaTown 8. Date of Birth Month, Day, Ye 9, Birthplace (State or Foreign Country) Sex 1 M M 2 □ F ecurity Number 6. Age (In yrs. last birthday) **Funeral** Min 242-60-750 Usual Residence of Decedent Days Hours Months Yrs. Larolina Director filed within 72 hours after deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itama 23a or 28a-f ahow the Modical Exportment that be notified at 1 Yes 2 □ No Md more Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 2 tive Funeral Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Isaac Humphrey 18. Mother's Name (First, Middle, Maiden Sumame, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any jury or other traumatic avant once. 17. Father's Name (First, Middle, Last) Be 5 19a. Informant's Name/Relationship (Type, Print) (Stanificant 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Oth Ms. Mae 02 Helen 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place. 1 Burial 2 ☐ Cremation 3 Removal from State 12/30/2010 Memorial 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Joseph L. Russ Funeral Home, P.
Joseph L. Russ Funeral Home, P.
Joseph L. Russ Funeral Home, P.
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Joseph L. Russ Funeral Home, 21. Signature of Funeral Service Licensee 16 atelle Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metas Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician end d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should I 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe certificate 1 Yes 2 No To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case re ferred to medical examiner? Hospital: Other: P 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier. 14451C/An 43 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 W. BALTIMORE ST. BALTIMORE, MD 21923 PREETINDER SANDHU mo 32 Adjistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 29 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:30 PM Barbara Ann Harris DECEMBER 24 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTWOOD CENTER Baltimore County GENESIS Lutherville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 F 255-74-3720 Dec. 27, 1942 Director Chickanauga, GA. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a, State "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 🔼 No Director Maryland Baltimore County Cockeysville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10 Pine Bark Court 21030 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: African Amer. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Nursing Aid 12 permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Hines Mattie Hines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms.Doretha A.McCoy (Daughter) 10 Pine Bark Court Cockeysville, Maryland 21030 20b. Place of Disposition (Name of 20a. Method of Disposition
1 Burial 2 Cremation Friday, Evans Fureral Crete and Cremation Services, Inc. (Harford County) 3 Removal from State Dec. 31, 2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Facilities Funeral & Cremation Center, P.A. A Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 Approximate Interval Between Onset and Death 23a. Part I Ehter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ORONAR) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☑ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Nonknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 2 No 1 Yes 2 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P After thi 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

レバト レイト イ Division or Vital Records, P.O. Box 68760 To the Hospital

with the Maryland

hours after

Maryland 21215-0036

Lov

State Registrar

Medical

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

3. Registrar's Signature

in Awarda, MD

29d. Date signed (Month, Day, Year)

DO061789. DECEMBER, 27,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOPPAINE OFORI-AWUAH MD. 5430 CAMPBELL BLVD. STE 214. BALTIMOTE MD 21236

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Anne E. Hofmann 12:01 AM 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lutherville Baltimore 12111 Tullamore Ct Unit 404 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 11-8-1928 1 🗆 M 2 🔀 F Months Days Hours Min Baft., Maryland 82 **Director** 217-24-3324 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director Lutherville Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen_of What Country? ò must be r United States Funeral 12111 Tullamore Court Unit 404 21093 America items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 ☐ Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natuiury or other traumatic event, the Medical jury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Mail Processor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gertrude Ziolo Francis Kucinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kingsville, Maryland 21087 Kimberly McDermott/ daughter 11250 Belair Road permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemeter), crematory or other place)
Evans Funeral
Chapel-Bel Ai 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State December 4 Donation 5 Other (Specify) 30, 2010 Forest_Hill, Maryland Signatury f Fund ral Service La ensee 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. Timonium, Maryland 21093 2325 York Road 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 2 Vel shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ OVANIAN Cancinoma Venu disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy Day Month Year 5 ☐ Other (specify) ed by the a detached f ned by t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe µertormed? 1 ☐ Yes 2 No certificate I 1 🗌 Yes 2 🗌 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: 5 Pending s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ■ Certifying Nurse Practioner To the best of my increased by Jeath undersal at the time, date and place, and due to the causalist and mariner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ December 29,2010 who completed cause of death (Item 23a) (Type, Print) Manyland

State Registrar

Charles

6569 North

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death OSPITAL BACTIMORE If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 ☑ M 2 ☐ F Date of Bird. (Month, Day Funeral Months Days Hours Yrs Director Residence of Decedent 28a-f shov 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 No nore 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hoursment of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Malden Surname) မှ Harrington Sister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory 1 Burial 2 Cremation 3 Removal from State Department or Important: If any injury or 2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Joseph L. Russ 21. Signature of Fun all Service Licens Ho 95a 21216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inserand Death Immediate Cause (Final 5 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Uniderlying Cause (Disease or linjury that initiated events sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performe death? 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Apatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 🗌 Yes 2 🖵 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

JOSEPH

31. Date filed (Month, Day, Year)

10515

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

Registrar's Sign

05

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Edm 120 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year Sept. 27 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 215-89-1545 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at **Funeral Director** .50r 10g. Citizen of What Country? ō 23a Was Decodent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ▼ Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify Yes. Give ş 3 Widowed 4 Divorced Year or Dates "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene.

is marked other than injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 2708 carborough labitha 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Log 22. Name and Address of Facility Vaughn & Greene Funeral 5151 Baltimore National 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final cardia **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last and Box 68760. attending physician Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Yes Completed 24a. Was an

The law requires that the death certificate be executed Division of Vital Records. has

or Attending Physician: Director: After death

filled in by the funeral within 24 hours a

To the Funeral D the Hospital completely

Be

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Certification:

Medical

State Registrar

Hospital: 1 Inpatient 2 ER/Outpatient 3 🗌 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year)

1 Yes

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

erson who completed cause of death (Item 23a) (Type, Print)

de Registrar's Signature

5 Pending investigation

6 Could not be

determined

25. Was case referred to medical

29b. Signature and title of certifier

filed (Month, Day, Year)

2 No

examiner?

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

one)

4 Homicide

(check only

1 Yes

4c. County of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ¥Yes 2 □ No

14. Race - American Indian Black, White, etc.

IacK 16b. Kind of Business/Industry

Windsor Mill MD 21244 20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Day

23e. Did tobacco use contribute to the cause of death?

Year

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? performed' 2 No 2 🗌 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 29c. License number 6636

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nestern Maryland Social Security Number 6. Regional Center Allegani Medical mberland 8. Date of Birth (Month, Day, Ye Oct. 27, 1 9. Birthplace (State or Foreign If Under 7. Age (In yrs. last birthday) Funeral 1 **X** M 2 □ F Months Days Hours Min. Country) Director 65 579-56-5200 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any highly or other traumatic events any highly or other traumatic events. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Allegany Lonaconing 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26 Douglas Avenue 21539 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces? Black White etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement 12 Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Huestis Ruth Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) Mr Barry M. Heustis Jr./Son 26 Douglas Avenue Lonaconing MD 21539 20a. Method of Disposition 20b. Place of Disposition (Name of December 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem.Park 29, 2010 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services.PA 1 2nd Ave. SW Glen Burnie MD 21061 Part 1, Extended disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1, Exter the Interval Between Onset and Death Immediate Cause (Final ₽hysician/ a Ventricular disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iiniury that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CABG, Diabetes Mellitus, Hypertension 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Vascular Visease autopsy 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 DOA ြု 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No **M** Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 D 0056526 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

9

Cumberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day MARY BARBARA HILD 8:03 PM Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Rosedale Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 □ XF Months Days Hours Min. MAR. 8, 1928 Director 220-24-5166 82 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6709 EVERALL AVE 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE "natural", 3 XWidowed 4 Divorced Specify Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES BRAID MARIA FAHEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK HILD-SON BALTIMORE, MD 21234 TOPWOOD CT 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Buria 2 Cremation 3 Removal from State PARKWOOD CEMETERY 12/30/10 BALTIMORE, MD 5 Dther (Specify) 4 Don tion Signatu of F 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or beart failure. List only one cause on each line. Approximate mmediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) AOrTIC aneur Abdominal Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 2 1 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death.

Le Funeral Director; Af oldered filled in by the fu Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 **To the** I only one) Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 1)54702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLin NoNa Novello Sauare DR Balto 2123 mal 31. Date filed (Month, Day, Year) State NEC Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Maryla		rtment of l				ene g. No. 2 ()	10	40993	
	Physicia	1. Decedent's Name (First, Middle, Last) FANNIE N. HASSELBERGER						2. Date of Death Amonth				Year	3. Time of Death	
	/Medic Examin							4b. City, Town, or Location of Death					212	
		.	Baltimore-Washing	ton Medica	al Center		Glen Bu				Ar	ne Arı	undel	
	Funeral Director		219-28-6226	6. Sex 1 □ M 2 ⊠ F		s. last birthday) Yrs.	If Under 1 Year Months Days		Min	Date of Birth (Month, Day, gust 22,	^{Year)} 1934	9. Birthp Cour Virg		
1	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Loc	ation					1	0d. Inside City Limits	
7	Maryl -f sho	ţo	Maryland Anne	Arundel		Lin	hicum						1 ☐ Yes 2 📉 No	
H	with the Maryland sa or 28a-f show)irec	10e. Street and Number	AL UIRICA		T-TTX I	10f. Zip Code			10	g. Citizen of V		ntry?	
56	23a c	ral	427 Cleveland Roa				210				U.S.A			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrainer mast be refilled at ance.	Funeral Director	11. Marital Status1 ☐ Never Married 2 ☐ Marri	Armed 1 ☐ Yes	ecedent Ever in Forces? s 2 No		Vas Decedent of Yes, specify Cub			y Yes or No- an, etc.)	Blac	k, White,		
E 升 5 12 15-0036 Maryland 21215-0036	hours a tural", c	ed by	3 🗷 Widowed 4 □ Divorced 15. Decedent	If Yes, 6 Year or	Dates:		□Yes 2 No lent's Usual Occu			11	Specify 6b. Kind of Bu	,,,,		
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772	d with	Com	12	O O	(1-401 5+)	Medica	l Transcri	4			dvanced		logy	
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∭. E	alth ar 27 is 27 is er trau		Michele N. Hasselbe		ighter)		Cleveland				-		,	
More,	es 1 a of He of He fitem		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		20b.		sition (Name of natory or other pla		Date		0c. Location -		own, State	
3	t. Pag tment tant: I		4 Donation 5 Dother (Sp	ecify)	G:	1	Mem. Park		Dec. 30,		1en Burr			
Barri	permit Depar Impor any Ir		21. Signature of Funer 15 rvice to	icensee	Sulu	22	Name and Addr B7 East Pa	ess of Facili tapsco	Avenue,	illy—Poly Baltimo	niak Fur re, Mary	neral l rland :	Hame P.A. 21225	
			23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Onset and Death											
	Physician		imprédiate Cause (Final présease or condition a. As Tation Presulting in death)											
1	/Medical Examiner		Due to (or ease consequence of):											
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due t	to (or as a conse	equence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to						nguence off:						- 17		
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Вох	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	outcome of preg	etaldeath 3 ☐	Ectopic pregnar	псу			1	te of deliv	ery Day Year	
o.	the de y the a ched f	ysic	1 □Yes 2 □No 9 □ Unknown	4∐Pro 9□Un	egnant at time o iknown	of death 5∟	Other (specify)							
ر. ح.	s that gned b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								acco use con	co use contribute to the cause of death?		
ord	equire sen siç ould b	ted k								1 ☐ Yes	1/1/10	3 Pro	bably 4 Unknown	
Jec.	e law r has be	Completed								24a. Was an autopsy perform		Were auto prior to co death?	opsy findings available ompletion of cause of	
To the same of the conditions								1 □ Yes 2 □ No 26. Place of Death (Check only one)						
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siol	Attending I er death. rector: After by the funer.	catic	2 Accident investig	ation			M 1 [□Yes 2□						
Divi	al or At after d Direct d in by	Certification: To		Manner of Dea h Manner of Dea			eet and Numl State)	and Number or Rural Route Number, ate)						
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	Medical C									stated. to the cause(s)			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								29c. License number 29d. Date signed (Month, Day, Year)						
								7	December 27 2010					
	3√		30. Name and a press of person	who completed ca	ause of death (It	em 23a) (Type,	Print)	Elan	Barn	nao.	mo.	710	bi,	
	Sta	te	31. Date filed (Month, Day, Year)	32	. Registrar's Sig	natur	nuv	July 1	- XYYII	TA P	1.4.	7	-/	
	Registr	ar	DEC 2 9 2010	Denou	2 B.	parke						<u> </u>		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Elizabeth D. Hobday Isaac 2010 2:45P Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🔀 F Min (Month, Day, 05/28 **Director** 216-14-0976 98 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No Westminster MD Carroll 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 507 High Acre Drive 21157 USA items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Maryland 21215-0036 72 hours after 1 ☐ Yes 2 😾 No Specify. 3 X Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than County Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Frederick Diebel Minerva Cox should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter-Page 1 and 2 Barbara Hobday_ 2036 Shreeveley Ln. Finksburg.MD 21048 Baltimore, In-La₩ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Timonium, MD 4 Donation 5 Other (Specify) Dulaney Valley 01/06/2011 Signature de Juneral Service Licensee ^{22. Name and Address of Facility}Fletcher Funeral Home 254 E. Main St.,Westminster,MD 211 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying death certificate be executed Dause (Disease or imjury and that initiated events Due to (or as a consequence of): resulting in death) Last as the burialphysician Physician/Medical Box 68760 IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death signed by the a 9 Unknown Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Kidnes 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature of person who completed cause of death (Item 23a) (Type, Print) Memorial Avenue Westminster, Mis State Registrar

DRMH 17 FISH 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 24, 2010 MARIA CLARE INFUSSI 11:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON MANOR CARE RUXTON Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months 1 M 2 F Days Hours Min FEB 1918 92 Yrs MD 217-01-9024 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 21014 USA 809 HURLEY CT death \ 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc.
WHITE 1X Never Married 2 ☐ Married by 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CONTACT REPRESENTATIVE **IMMIGRATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANGELINA BIANCHNELLO MARION VINCENT INFUSSI 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 809~HURLEY~CT~~BEL~AIR , MD 21014permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau CLARE DIPPEL-NIECE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/29/10 HOLY REDEEMER CEM. BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Incret 1 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BEALIR RD BALTIMORE, MD 21206 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph_sician/ disease or condition resulting in death) nd Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate

Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached 1 L Yes 2 L 9 Dunknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à or Attending Physician; The law requires disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 100 မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 69540 M.D. 2010 -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) woods Rd Swite Sarkwille 8813 Walhan 204 Jigar. Shah 31. Date filed (Month, Day, Year) State 2 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month gremous Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death owsor more TO If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Months Days Hours Min Country) 1 \square M 2 a Director Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Nes 2 No timale WING 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2111 Funeral Wood 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Yes, Give Maryland 21215-0036 Yes 2 No Specify. "natural" 3 Nidowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of thealth and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medicall any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 1.2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) yons wood ordan DWINGS Mills Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MI) 4 Donation 5 Other (Specify) etro Si nature of Funeral Service Licensee 1 toke 2120 Heights 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Life to for as a consequence off if any leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death No been signed by the s should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably A Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 🗌 No 1 🗌 Yes Yes 2 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 Other: ၉ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Accident
Suicide
Homicide fter des th Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signatur License number and address of person who completed ca se of death (Item 23a) (Type, Print) 32. Registrar's Signature State

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Registrar

Registrar

State

Baltimore VA Medical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Sign

D0035363

10 N. Greene St. Ralbomore

MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 December 10:28 A D. Kuny Lucy Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Hours Aug 5, 1929 1 □ M 2 🛣 F Massachusetts 015-22-6021 81 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10c. City, Town or Location 10a. State Director Gaithersburg 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20878 221 Booth Street, #313B Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mercedes Botelho John DeCosta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 221 Booth Street, #313B Gaithersburg, MD 20878 James A. Kuny/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 12/27/2010 Woodbine, Maryland 21. Sign tu e of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 innite Thomas M00957 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ espiratory disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 5 month Malnutrition Sequentially list conditions, Due to for as a consequence of thank teading to immedia cause. Enter Underlying Cause (Disease or iinjury Congestive Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death After this certificate has been signed by the functional director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕍 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Tho ပ 1 Tyes 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation after death 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ร 24 hours a e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 🗌 only one) 29c. License number 29d. Date signed (Month, Day, Year) 70144 30. Name and address of person who completed caused death (Item 23a) (Type, Print) CXT ST 9901 Medical MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f Per INF G912 2/01/2011 JH State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 24, 2010 Physician/ 9:40 P M Dorothy R. Kahal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY Brighton Gardens Asst. Living Bethesda 8. Date of Birth (Month, Day, Year Jan 22, 1 9. Birthplace (State or Foreign Country) New York 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min Days 1 □ M 2 🏻 Months Hours 055-03-1703 **Director** 1918 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Florida Palm Beach Boynton Beach XX Yes 2X No MD: <u>Montgomery</u> 8258 Horseshoe Bay Road 11401 Duryea Drive 10f. Zip Code 10a. Citizen of What Country? 33472 Funeral 20854 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Edelman Michael Raisin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew I. Kahal/son 11401 Duryea Drive Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 12/29/10 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Sing Home CRemation Service P.O. Box 784 Clarksville, MD 21029 MO1251 Beverly L. Heckrotte, P.A. 23a. Part 1. Enter the glease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 years Immediate Cause (Final Trysician/ Conjestive Heart Failure disease or condition a. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No signed by the atte Month Day Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Chronic Renal Insufficiency should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No his certificate h 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA ည After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation nours after death neral Director: / the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and

Registrar

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Sheff, M.D. 10215 Fernwood Road Be

224 Begistrates Sign

D36797

Bethesda, MD 20817

December 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 12:25 A M Rudolph Earl Kunkel, Jr. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ≧xaminer 2903 Fairland Road Montgomery Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1^{Year)} 1<u>926</u> 1 🕅 M 2 🗆 F Days Hours Min 267-28-8955 Florida Director 84 Usual Residence of Decedent at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 🗌 Yes 2 🔀 No NC Craven New Bern 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6308 Albatross Drive 28560 United States "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian Black, White, etc. 1 ☐ Never Married 2 🙀 Married 1 X Yes 2 ☐ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates. 1944-46 Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rudolph Earl Kunkel, Sr. Martha Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Mapleton Kunkel/wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 6308 Albatross Drive New Bern, North Carolina 28560 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 12/30/2010 | Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 uanta Rahmar M00957 Beverly L. Heckrotte, P.A. Clarksville 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Aspiration Pneumonitis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): executed Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as. attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Normal Pressure Hydrocephalus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Arteriosclerosis Cerebrovascular Disease Jas autopsy performed? death? certificate Yes 2X No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Hospital: 1 ☐ Yes 2 XNo Daughter's မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No Investigation 2 Accident the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Benad a. Hubman, M.D. D0005373 December 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Bernard Heckman, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

8830 Cameron Court, #405 Silver Spring, Maryland 20910